

FILED SEP 13 1944

Registration District No. 3041

Registrar's No. 84

61
3
2

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Macon

(a) County Macon

(b) City or town Macon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Macon
(If outside city or town limits, write "RURAL") 2

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Celia Johnson

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race 3 Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Sept 22 - 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days 11 If less than one day hr. min.

9. Birthplace Randolph Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation house keeper

MOTHER FATHER

11. Industry or business.....

12. Name Jefferson Johnson

13. Birthplace Mo
(City, town, or county) (State or foreign country)

14. Maiden name Celia Perkins

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mo Wm Grant

(b) Address Macon Mo

17. (a) burial (b) Date thereof Aug 6-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director Adelt Skidmore

(b) Address Macon Mo

19. (a) 8/11/44 (b) Wm B. Junkler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3
year 1944 hour 8 minute 1 M.

21. I hereby certify that I attended the deceased from after she was dead, 19....., to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Chronic Endocarditis

Due to Chronic Nephritis

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations..... 131 f

Of autopsy.....

Duration.....

PHYSICIAN.....

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work..... (Specify type of place) (e) Means of injury.....

23. Signature A.C.D. Edwards (M. D. or other) MD
Address Macon Mo Date signed 8/19/44

1057

RECEIVED

District Health Officer No. 10

District File Number 9-44-1605

Date Filed SEP 12 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.