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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 5, 1944

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30831

State File No.

Primary Registration District No. 5392

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Dent

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

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

(d) Length of stay: In hospital or institution x (Specify whether
In this community most of her life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33

(c) City or town rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. x 0
(If rural, give location)

(e) Citizen of foreign country? x (Yes or No)

If yes, name country x 0

3. (a) PRINT FULL NAME Myrtle Irene Johns

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex female

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Chas. H. Johns

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased June (Month) 16 (Day) 1898 (Year)

8. AGE: Years	Months	Days	If less than one day
46	2	26	hr. min.

9. Birthplace Montgomery Co (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation housewife

11. Industry or business x

FATHER
12. Name Clark J Davis
13. Birthplace Warran Co (City, town, or county) Mo (State or foreign country) 0

MOTHER
14. Maiden name Viola Bell Shaw
15. Birthplace Roachport (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant Chas Johns
(b) Address Salem Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (Month) (Day) (Year)
(c) Place: burial or cremation Ft Herman

18. (a) Signature of funeral director Carl H Johnson
(b) Address Salem Mo

19. (a) 9-12-44 (Date received local registrar) (b) Jas. W. McLeod by Mob (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9
year 1944 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 9, 1944, to , 19 ;
that I last saw her alive on Sept 9, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature Leslie Randall (M. D. or other) MD
Address Lecking Mo Date signed 9-13-44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5
District File Number 104492
Date Filed 10-4-44

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 .....

Licensed Embalmer No. 1237

P. O. Address Salem Me

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.