

No. 2
1-2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38291

State File No. _____
Registrar's No. 14

FILED DEC 5 1944
Registration District No. 199

Primary Registration District No. 4311

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

1. PLACE OF DEATH: Macon
(a) County Callas
(b) City or town Callas
(c) Name of hospital or institution: _____
(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

3. (a) PRINT FULL NAME Margaret A. Johnson
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Female 5. Color or race wh. 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 6-9-1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 4 22 hr. _____ min.

9. Birthplace Jacksonville Ill
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Emmely Chrisman

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

14. Maiden name Johnson

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

16. (a) Informant Ben F. Johnson
(b) Address Callas, Mo

17. (a) Burial (b) Date thereof 11-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Sofya Mo

18. (a) Signature of funeral director W. S. Edwards
(b) Address Twier Mo
19. (a) Nov 10 1944 (b) W. S. Edwards
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Macon
(c) City or town Callas
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 1
year 1944 hour 5 minute P M.
21. I hereby certify that I attended the deceased from _____
_____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis
Due to die without medical care

Due to found dead

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

Major findings: Of operations 1318
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Natural death
(b) Date of occurrence 11-1-44
(c) Where did injury occur? Callas Macon Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home
While at work? no (Specify type of place) (e) Means of injury Natural death
23. Signature W. S. Edwards
Address Twier Mo Date signed 11/1/44

Duration 3 years
PHYSICIAN
Underline the cause to which death should be charged statistically.

1045

MAR 15 1945

MAY 10 1945

RECEIVED
District Health Officer No. 10
District File Number 12-44-1932
Date Filed DEC 4 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 J. H. Edwards

Licensed Embalmer No. 1961

P. O. Address Berwick, 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.