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17-39
X37823

Registration District No. 290 Primary Registration District No. 5984

1. PLACE OF DEATH:

(a) County Dulaski
(b) City or town Brownfield Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dulaski?
(c) City or town Brownfield Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Florence Annie Johnson

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 17 1895
(Month) (Day) (Year)

8. AGE: Years 49 Months 3 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation Brownfield Mo

11. Industry or business _____

12. Name Daniel Nicks

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

14. Maiden name Ann Isdale

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

16. (a) Informant Mrs Carl Nicks

(b) Address Stuyley Ave Mo

17. (a) Rural (b) Date thereof 11-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director R B Jester

(b) Address Richland Mo

19. (a) 11-20-44 (b) Chas M Dodd
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6
year 1944 hour 1 minute 0 a.m.

21. I hereby certify that I attended the deceased from 8-15-, 1944, to 11-6-, 1944
that I last saw her alive on 10-15-, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung Duration 1 yr

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

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) (c) Means of injury _____

23. Signature C. Miller M.D. (M. D. or other) _____
Address Waynesville Mo Date signed 11-18-44

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

APR 19 1945

MAY 29 1945

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. 3198

P. O. Address.....

Richland 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____ JAN
Registrar's No. 186

Registration District No. 240

Primary Registration District No. 5984

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

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Rural Liberty Miss
(If outside city or town limits, write "RURAL" and name of township)
(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 Florence A. Johnson

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

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

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

7. Birth date of deceased: July 17 (Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days _____ (Unless than one day) min. _____

9. Birthplace Pulaski Miss (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 July year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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 _____ (M. D. or other) _____
Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-41924 1944