

Registration District No. **349** Primary Registration District No. **4513**

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Green Castle
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Green Castle
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 45 yrs.
years, months or days

3. (a) PRINT FULL NAME Lillie Lester Johnson
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex 7 1 Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Chas. E. Johnson 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased 3 6 1868
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Antirim Lester
13. Birthplace Quakertown Penn.
(City, town, or county) (State or foreign country)
14. Maiden name Farnest White
15. Birthplace Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. E. Johnson
(b) Address Green Castle Mo.

17. (a) Burial (b) Date thereof 12-10-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Green Castle

18. (a) Signature of funeral director Allen E. Paulson
(b) Address Green City Mo.

19. (a) 12-30-44 (b) Kaura M. Shaw
(Date received local registrar) (Registrar's signature) (Date)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Sullivan ¹⁰⁵
(c) City or town Green Castle ¹
(If outside city or town limits, write "RURAL.")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6
year 1944 hour 6 minute 40 P.M.
21. I hereby certify that I attended the deceased from 4-77
1944 to 12-6 1944
that I last saw her alive on 12-5 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Paralysis
Apoplectic Stroke
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

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

Major findings: Of operations 108
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? _____
(Specify type of place) _____
(e) Means of injury ?
23. Signature J. P. Deane (M. D. or other) _____
Address Green City Mo. Date signed 12-9-44

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

05
605

RECEIVED
District Health Officer No. 10
District File Number 1-45-9
Date Filed JAN 3 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

Archie W. Wade

Licensed Embalmer No.

3037

P. O. Address

Green City, 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.