

**FILED FEB 9 1945**

Registration District No. **23**

Primary Registration District No. **#55336**

Registrar's No. **72**

1. PLACE OF DEATH:

(a) County Dade  
(b) City or town Rural Center miss  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4 miles north Greenfield  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 74 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade **29**  
(c) City or town Rural **0**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4 Miles N. of Greenfield  
(If rural, give location)  
(e) Citizen of foreign country? ✓ (Yes or-No)  
If yes, name country U

3. (a) PRINT FULL NAME MARTHA L. JOHNSON

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

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

6. (b) Name of husband or wife Frank 6. (c) Age of husband or wife if alive 18 years

7. Birth date of deceased September 18 1870  
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 5 If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business Home

12. Name Marshall Young

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

14. Maiden name Matthie McCure

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

16. (a) Informant John Johnson

(b) Address Greenfield mo

17. (a) Burial (b) Date thereof 1-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield Cemetery

18. (a) Signature of funeral director Sam E. Sweeney  
(b) Address Greenfield, Mo.

19. (a) 1/24/45 (b) Phyllis Lack  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23  
year 1945 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 20 1945, to Jan 23 1945  
that I last saw her alive on Jan 23 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to apoplexy

Due to apoplexy

Other conditions: apoplexy  
(Include pregnancy within 3 months of death)

Major findings: apoplexy  
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? apoplexy (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. O. Cavan (M. D. or other)  
Address Greenfield Mo Date signed 1-24-45

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number

245-163

Date Filed

FEB 6 1945

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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

*Sam E. Senseney Jr*

Licensed Embalmer No.

4099

P. O. Address

*Greenfield 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.**