S. No. 2
M—5-42
. 5-17-39
PT X32873

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

Dr. Musick

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 8 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2220

Registration District No. 128 | Primary Registration District No. 2000 | Registrar's No. 62

1. PLACE OF DEATH:

(a) County: GREENE

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

(c) Name of hospital or institution: 631 S. Grant (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 3 Days (Specify whether years, months or days)

In this community: 65 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield (If outside city or town limits, write "RURAL")

(d) Street No.: 446 South (If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Marshall R. Johnston

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: UNK.

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

7. Birth date of deceased: Dec. (Month) 4, (Day) 1856 (Year)

8. AGE: Years	Months	Days	If less than one day
88	1	16.	hr. min.

9. Birthplace: UNK. (City, town, or county) Pennsylvania (State or foreign country)

10. Usual occupation: Retired

11. Industry or business: Frisco R.R.

MOTHER FATHER

12. Name: Unknown

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

14. Maiden name: Unknown

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

16. (a) Informant: Harry Johnston

(b) Address: St. Louis, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1/23/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Kansas City, Mo.

18. (a) Signature of funeral director: H.H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 1-23-45 (Date received local registrar) (b) O. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20 year 1945 hour 2:00 minute a. M.

21. I hereby certify that I attended the deceased from 12,14,1944, 19..., to 1,20, 1945 that I last saw him alive on 1,19, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis, chronic	About two months
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: J. Musick (M. D. or other)

Address: Springfield, Mo. Date signed: 1,22,45

(Licensed Embalmer's Statement on Reverse Side)

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 L. Doolin Forman

Licensed Embalmer No. 3177

P. O. Address Springfield 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.