

No. 2
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5-17-39
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U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 3 1945
Registration District No. 300

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3859
Registrar's No. 5

Primary Registration District No. 6225

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

1. PLACE OF DEATH:
(a) County: Vernon
(b) City or town: Rural Washin. Hosp.
(c) Name of hospital or institution: State Hosp. no 3.
(d) Length of stay: 7 days & 8
In this community: Same time

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 10
(c) City or town: Kansas City
(d) Street No.: 3021 Mc Gee
(e) Citizen of foreign country? No.

3. (a) PRINT FULL NAME: Margaret Johnston
3. (b) If veteran, name war: -
3. (c) Social Security No.: unk.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month: Jan day: 5
year: 1945 hour: 5:30 minute: A M.
21. I hereby certify that I attended the deceased from 12-29-44
to 1-5-45
that I last saw her alive on Jan 5 - 1945
and that death occurred on the date and hour stated above.

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife: William Johnston
6. (c) Age of husband or wife if alive: unk. years
7. Birth date of deceased: June 24 - 1898

Immediate cause of death: Hypostatic Pneumonia
Due to: _____
Due to: _____
Other conditions: _____
(Include pregnancy within 3 months of death)

8. AGE: Years: 56 Months: 6 Days: 6
If less than one day: hr. min.

9. Birthplace: Illinois
10. Usual occupation: Housework
11. Industry or business: Own home

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name: } no record }
13. Birthplace: } }
14. Maiden name: } }
15. Birthplace: } }
(City, town, or county) (State or foreign country)

16. (a) Informant: Hosp. Records
(b) Address: Nevada Mo.
17. (a) Removal: (b) Date thereof: Jan 5 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Kansas City, Mo.
18. (a) Signature of funeral director: Allen Stamps
(b) Address: Nevada Mo.
19. (a) 1-5-45 (b) Hotel B. Bevel
(Date received local registrar) (Registrar's signature)

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: P.B. Lester
Address: Nevada Mo. Date signed: 1-5-45

1331

RECEIVED

District Health Officer No. 7;

Date: 1-4-5-15

2-5-45

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: *Allen S. King*
Licensed Embalmer No. *1968*
P. O. Address: *Nevada 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.