V. S. No. 2
0M—8-43
ev. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5530

Registration District No. 37 — Primary Registration District No. 4049 — Registrar's No. 4

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Centralia
(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 years, months or days)
In this community: ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Boone
(c) City or town: Centralia
(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: ✓

3. (a) PRINT FULL NAME: Elizabeth Jewell 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: ✓
6. (b) Name of husband or wife: ✓
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: Dec (Month) 28 (Day) 1944 (Year)

8. AGE: Years 0 | Months 1 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace: Centralia (City, town, or county) Mo (State or foreign country)
10. Usual occupation: ✓
11. Industry or business: ✓
MOTHER FATHER
12. Name: Millard Turner Johnson
13. Birthplace: Callaway Co. (City, town, or county) Mo (State or foreign country)
14. Maiden name: Helen Jennings
15. Birthplace: Centralia (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Helen Johnson
(b) Address: Centralia Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-1-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Centralia Mo
18. (a) Signature of funeral director: M. McKausel
(b) Address: Centralia Mo
19. (a) 1/31-1945 (Date received by local registrar) (b) Chas J. Wright (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31 year 1945 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from Jan 1, 1945, to Jan 31, 1945; that I last saw her alive on Jan 31, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia — Duration: 5 days
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 108
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: R. P. Roberts M.D. (M.D. or other)
Address: Centralia, Mo Date signed: 1-31-45

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-8-45

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 M D McDaniel

Licensed Embalmer No. 4313

P. O. Address Centralia 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.