

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13207A  
Registrar's No. 20

Registration District No. 70

Primary Registration District No. 4164

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Altamont  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
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(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 10 Yrs.  
years, months or days)

3. (a) PRINT FULL NAME Mary Carrie Johnson

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charles M. Johnson 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased April 15 1865  
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Daviess County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name William Johnson

13. Birthplace Pendleton County West Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Kee

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

16. (a) Informant's own signature Chas. M. Johnson  
(b) Address Altamont Missouri

17. (a) Burial (b) Date thereof 2-27-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Ayr Cemetery

18. (a) Signature of funeral director Hope Funeral Home  
(b) Address Gallatin, Missouri

19. (a) 3-6-1945 (b) L. O. Richeson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess  
(c) City or town Altamont  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 24  
year 1945 hour 11 minute 58 P. M.

21. I hereby certify that I attended the deceased from Jan 2, 1945, to Feb 11, 1945,  
that I last saw he alive on Feb 11, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart Disease

Due to Coronary Arteriosclerosis and Arteriosclerosis of Blood Vessels

Due to None

Other conditions (Include pregnancy within 3 months of death)

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

23. Signature John Flanku (M. D. or other) \_\_\_\_\_  
Address St. Charles, Mo. Date signed 2/24/45

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

0021-8-1 Rev. 5-17-39 11 x1011

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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 *L. O. Richesson*

Licensed Embalmer No. *3302*

P. O. Address *Fallston, Md.*

**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, above space should be left blank.**