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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13412

Registration District No. FILED APR 25 1945

Primary Registration District No. 2000

Registrar's No. 291

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: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution few hours (Specify whether
In this community few hours
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster

(c) City or town Rural 1/2
(If outside city or town limits, write "RURAL")

(d) Street No. E. Union township.
(If rural, give location)

(e) Citizen of foreign country? No 1 (Yes or No)

If yes, name country x

3. (a) PRINT FULL NAME Kathryn Marie Johnston

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 Single

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive x X years

7. Birth date of deceased August - 13 - 1934
(Month) (Day) (Year)

8. AGE: Years 10 Months 7 Days 24 If less than one day x hr. x min.

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

10. Usual occupation Student

11. Industry or business School

FATHER
12. Name Robert Johnston
13. Birthplace Webster Co., Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Essie Bledsoe
15. Birthplace Webster Co., Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. + Mrs. Robert Johnston
(b) Address Niangua, Missouri

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4-10-45
(Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Amity

18. (a) Signature of funeral director Rex Jainey
(b) Address Marshfield, Mo.

19. (a) 4-9-1945 (Date received local registrar) (b) Dr. W E Gaudry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 7 day 7
year 1945 hour 8:00 PM minute M.

21. I hereby certify that I attended the deceased from 4-7, 1945 to 4-7, 1945
that I last saw her alive on 4-7-, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Gen Peritonitis

Due to

Due to Ruptured Appendix

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation

Of autopsy ✓

Duration

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 E C Rosden (M. D. or other)

Address Spfd., Mo. Date signed

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(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 Rex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.