

FILED JUN 14 1945

Registration District No. 98

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16736

State File No.

Primary Registration District No. 4164

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Waverly  
(b) City or town Atta Mont  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Louella Johnson

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

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

6. (b) Name of husband or wife W.C. Johnson (c) Age of husband or wife if alive 78 years

7. Birth date of deceased Aug 19 1864  
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ohio (City, town, or county) (State or foreign country)

10. Usual occupation Retired Housewife

11. Industry or business

12. Name Blair Woodcliff

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

14. Maiden name Patricia Adams

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

16. (a) Informant H. B. Johnson

(b) Address Atta Mont no

17. (a) Burial (b) Date thereof May 27-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atta Mont

18. (a) Signature of funeral director Cate Shoup

(b) Address Winston, Mo

19. (a) 5-31-1945 (b) A. O. Fickens  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Davies  
(c) City or town Atta Mont  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24  
year 1945 hour 110 minute 55 P.M.

21. I hereby certify that I attended the deceased from September 12, 1936, to May 24, 1945;  
that I last saw her alive on May 24, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Chronic Hypertension  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 938  
Of autopsy \_\_\_\_\_

Duration several  
years  
several  
years.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Frank Wilson (M. D. certificate) \_\_\_\_\_

Address Winston, Missouri Date signed 5/31/45

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

MOTHER FATHER

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.....

working under my personal supervision.....

Registered Apprentice No.....

Signed.....

Date Filed  
District File Number  
District Health Officer No. 11

Licensed Embalmer No. 3302

P. O. Address Bellair, 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.