

S. No. 2
M-8.43
7. 5-17-39
X37823

17606

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 29 1945
Registration District No. 229

Primary Registration District No. 4343

Registrar's No. 41

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

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town New Florence Mo
(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 8 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montgomery
(c) City or town New Florence
(If outside city or town limits, write "RURAL") _____
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frankie May Johnson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Martin Johnson 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased 3-24-1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 19 hr. _____ min.

9. Birthplace Near Americus Mo
(City, town, or county) (State or foreign country)

10. Usual occupation home

11. Industry or business _____

MOTHER FATHER { 12. Name William Clark
13. Birthplace no
(City, town, or county) (State or foreign country)
14. Maiden name Martha Welkins
15. Birthplace no
(City, town, or county) (State or foreign country)

16. (a) Informant Wade Johnson
(b) Address New Florence Mo

17. (a) Burial (b) Date thereof 4-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Florence Cem

18. (a) Signature of funeral director C. W. Hopkins
(b) Address Montgomery City Mo

19. (a) April 17, 1945 (b) Mrs Oliver Zureich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
year 1945 hour 5 minute 40 a. M.
21. I hereby certify that I attended the deceased from April 14
1945 to April 15 1945
that I last saw her alive on April 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation Rt. Ventricle of heart
Due to acute myocarditis
Due to fatly degeneration of heart
Other condition infarction
(Include pregnancy within 3 months of death)

Duration
 sudden
 1 day
 2 days

Major findings:
Of operations none
Of autopsy none
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) acc
(b) Date of occurrence 4-15-45
(c) Where did injury occur? at home
(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 James O. Helm (M. D. or other) _____
Address New Florence Mo Date signed 4-16-45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-28-45

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 on the 13 th
day of April 1945.....; Registered Apprentice No.....
working under my personal supervision.

Signed C. W. Hopkins
Licensed Embalmer No. 1487
P. O. Address Montgomery City 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.