

FILED SEP 18 1945
Registration District No. _____

Primary Registration District No. 4296

Registrar's No. 21

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Browning
(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 Elizabeth Johnson
3. (b) If veteran, name war XXXX 3. (c) Social Security No. XXXX

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 5, 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>9</u>	<u>28</u>	hr. _____ min. _____

9. Birthplace Sullivan Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: At home

11. Industry or business _____

MOTHER FATHER
12. Name Andrew Jackson Cotter
13. Birthplace XXXXXXX Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Ellen Pipes
15. Birthplace Linn County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Elto Johnson
(b) Address Browning, Missouri

17. (a) Burial (b) Date thereof 8/5/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jenkins Cemetery

18. (a) Signature of funeral director Thorne Undt Co.
(b) Address Linneus, Mo. (D.A. Taylor)

19. (a) 8-5-1945 (b) Mrs. C.E. Wood
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn 58
(c) City or town Browning 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3rd
year 1945 hour 7 minute _____ P.M.

21. I hereby certify that I attended the deceased from Nov 1944 to Aug 3 1945

that I last saw h. e alive on Aug 3 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial degeneration 12y

Due to _____

Due to _____

Other conditions: fracture left hip 6 mo
(Include pregnancy within 2 months of death) Malnutrition

Major findings: Of operations _____

Of autopsy: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following: ON REQUESTED 58

(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 J.P.M. Carter (M. D. or other)
Address Browning, Missouri Date signed 8/4/45

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

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 Darr A. Taylor

Licensed Embalmer No. 3761

P. O. Address Linneus, Missouri

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 21

Registration District No. 183

Primary Registration District No. 4296

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Browning
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME

Elizabeth Johnson

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Oct 5 (Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 28 If less than one day _____ hr. _____ min.

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

MOTHER FATHER

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day _____ Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to fall in house

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 March 17

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

1860-5
18

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-27818