

**FILED DEC 15 1945**

Registration District No. 145

Primary Registration District No. 5516

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Iron  
 (b) City or town Rural, Iron  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1/2 mile west of Belleview  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community life  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Iron  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1/2 mile west of Belleview  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** William Jasper Johnston  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

**MEDICAL CERTIFICATION**  
 20. **DATE OF DEATH:** Month Nov day 5  
 year 1945 hour 10 minute 30 P. M.

4. Sex M 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Emma Johnston  
 6. (c) Age of husband or wife if alive 74 years  
 7. Birth date of deceased July 10 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 5, 1945 to Nov. 5, 1945  
 that I last saw him alive on Nov. 5, 1945  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>3</u>	<u>25</u>	hr. _____ min. _____

Immediate cause of death Pneumonia, Ac. lobar, rt. lower lobe  
 Duration 1 day

9. Birthplace Reynolds County, Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation retired, farmer

Due to Myocarditis, chronic 10 yrs.  
 Due to Arterial Sclerosis, general " "

11. Industry or business \_\_\_\_\_  
 12. Name Marion Johnston  
 13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Adams  
 15. Birthplace unknown  
(City, town, or county) (State or foreign country)

Other conditions None  
(Include pregnancy within 3 months of death)

16. (a) Informant Mrs. Dent McKinney  
 (b) Address Belleview Mo.  
 17. (a) burial (b) Date thereof 11-7-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Caledonia

Major findings: Of operations \_\_\_\_\_  
 Of autopsy 100%

18. (a) Signature of funeral director Norman White & Sons  
 (b) Address Quail White Ironton Missouri  
 19. (a) Nov 9, 1945 (b) Mrs. Edyth L. Logan  
(Date received local registrar) (Registrar's signature)

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 Ben M. Bill (M. D. or other) M.D.  
 Address Ironton, Mo. Date signed 11-6-45

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

49  
6  
0

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Arnel J. White*

Licensed Embalmer No. *3012*

P. O. Address *Scotts 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.**