

No. 2
A-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 30 1945
Registration District No. 278

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38220

State File No. _____

Primary Registration District No. 3054

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Ribe
(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 417 North 7th St 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 70 (Specify whether
In this community Lifetime years, months or days)

3. (a) PRINT FULL NAME Cora L. Johnston
(b) If veteran, name war No
(c) Social Security No. No

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Edward Johnston
(c) Age of husband or wife if alive, years 10 1873
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 10 24 < hr. < min.

9. Birthplace Ribe County Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at home

MOTHER FATHER
12. Name Thomas Houchins
13. Birthplace Ribe County Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Melba McCaskey
15. Birthplace Ribe County Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Edward Johnston
(b) Address Louisiana, Mo.

17. (a) Burial (b) Date thereof 10/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Frankford Mo.

18. (a) Signature of funeral director James Horne
(b) Address Louisiana, Mo.

19. (a) 10/17/45 (b) Margaret E. Dwyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ribe 82
(c) City or town Louisiana 2
(If outside city or town limits, write "RURAL")
(d) Street No. 417 North 7th St. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4
year 1945 hour 3:30 minute PM
21. I hereby certify that I attended the deceased from June 1st
1944 to Oct 4, 1945
that I last saw him alive on Oct 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pyelitis
Due to Pyelitis
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 1230
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J M Pearson (M.D. or other)
Address Louisiana Mo Date signed 10/16/45

1543

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 27 1950

RECEIVED

District Health Officer No. 10

District File Number 11-45-1724

Date Filed NOV 27 1945

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 *J. B. Stone*

Licensed Embalmer No. 4039

P. O. Address *Lansdowne, 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.