S. No. 2
M—1-4-41
v. 5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 13 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38692

Registration District No. 222 Primary Registration District No. 3071 Registrar's No.

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Slater
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community six months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline 97
(c) City or town Slater 2
(If outside city or town limits, write "RURAL")
(d) Street No. Main 1
(If rural, give location)
(e) Citizen of foreign country? ~~Yes~~ No (~~Yes~~ or No) 0
If yes, name country

3. (a) PRINT FULL NAME Bertha May Johnson

3. (b) If veteran, name war no
3. (c) Social Security No. 493-28-8147

4. Sex female /
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Samuel L. Johnson
6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased Sept. (Month) 9 (Day) 1908 (Year)

8. AGE:	Years	Months	Days	If less than one day
	37	1	18	hr. min.

9. Birthplace Boone County (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation house-wife
11. Industry or business
FATHER
12. Name Ben Wainscott
13. Birthplace Boone County (City, town, or county) Mo. 0 (State or foreign country)
MOTHER
14. Maiden name Don't Know
15. Birthplace (City, town, or county) Mo. 0 (State or foreign country)
16. (a) Informant Samuel L. Johnson
(b) Address Slater, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-'45 (Month) (Day) (Year)
(c) Place: burial or cremation Centralia, Mo.
18. (a) Signature of funeral director Hill Brothers,
(b) Address Slater, Mo.
19. (a) 12-4-'45 (Date received local registrar) (b) Mrs. Earl C. Metz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day Nov. - year 1945 hour 4 minute 30 p. M.
21. I hereby certify that I attended the deceased from held in guest Nov. 12, 1945 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Suicide.	
(32 Automatic)	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Yes -	

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) Suicide
(b) Date of occurrence Nov. 12, 1945
(c) Where did ~~injury~~ Suicide occur? Slater (City or town) Saline (County) Mo (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 C. L. Lawless Coroner Saline Co. (M. D. ~~another~~)
Address Marshall, Mo. - 2 Date signed 11-12-45

1549 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 12-13-45

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~~.....

.....; Registered Apprentice No.....,

working under my personal supervision.

Signed Sam M Hill

Licensed Embalmer No. 1292

P. O. Address Slater 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.