DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6314

FILED FEB 28 1946

State File No.

Registration District No. 383 Primary Registration District No. 3037 Registrar's No. 4

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt. Vernon (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) Lifetime

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence

(c) City or town Mt. Vernon (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sarah Elizabeth Johnson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced 2 widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 12 (Day) 1862 (Year)

8. AGE: Years 83 Months 9 Days 19 If less than one day hr. min.

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

10. Usual occupation House keeper

11. Industry or business

FATHER
12. Name Joe Avery
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Marshbank
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-1946 (Month) (Day) (Year)

(c) Place: burial or cremation 200 F. Cemetery

18. (a) Signature of funeral director H. G. Tassett

(b) Address Mt Vernon, Mo

19. (a) 1-12-46 (Date received local registrar) (b) C R Philbrick (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Dec day 31 year 1945 hour 12:50 minute P M.

21. I hereby certify that I attended the deceased from 2/1, 1941, to 12-31, 1945 that I last saw her alive on 12-30, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure - following Embolus - Rt. Axillary Vessel

Due to - Chr. myocarditis, Rt. pleurisy (Chr.)

Due to Effusion

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Kenneth Glover (M. D. or other)

Address Mt Vernon, Mo Date signed 4/5/46

159 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 146-140
FEB 26 1946

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 Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address Mt. Vernon, 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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. M 22

Registration District No. 383 Primary Registration District No. 3087 Registrar's No. 4

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mt Vernon
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence

(c) City or town Mt. Vernon
(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

3. (a) PRINT FULL NAME Sarah E. Johnson

3. (b) If veteran, name war

3. (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 years

7. Birth date of deceased Mar (Month) 12 (Day) 1862 (Year)

8. AGE: Years 80 Months 9 Days 19 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Joe Avery
13. Birthplace (City, town, or county) France (State or foreign country)

MOTHER
14. Maiden name Elizabeth Marshbanks
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant ( )
(b) Address ( )

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 (Month) 3 (Day) 1946 (Year)
(c) Place: burial or cremation I.O.O.F. Cem. Mt. Vernon

18. (a) Signature of funeral director H.D. Fossett
(b) Address Mt Vernon, Mo.

19. (a) (Date received local registrar) (b) C.R. Philbrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 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 Myocardial failure	
Due to Coronary disease	
Due to	
Other conditions Pneumonia — Lobar (subsiding) (Include pregnancy within 3 months of death)	3 wks

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)

While at work? (f) Means of injury

23. Signature Kenneth Glover M.D. (M.D. or other)

Address Mt Vernon, Mo. Date signed

6314