

No. 2  
8-43  
17-39  
X37823

FILED MAR 8 1946  
338

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 338

Primary Registration District No. 6148

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Bloomfield Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution STOODARD County Home 5  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6.0 yrs  
(Specify whether years, months or days)

In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County STOODARD MO

(c) City or town BLOOMFIELD  
(If outside city or town limits, write "RURAL")

(d) Street No. STOODARD COUNTY HOME  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY JOHNSON

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 19  
year 1946 hour 10 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from FEBRUARY  
1, 1946, to FEBRUARY 19, 1946  
that I last saw her alive on FEBRUARY 15, 1946  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 1863  
(Month) (Day) (Year)

Immediate cause of death Broncho pneumonia primary Duration 2 wks

8. AGE: Years 82 Months 1 Days 1  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions GENERALIZED Arteriosclerosis 15 yrs  
(Include pregnancy within 3 months of death)

10. Usual occupation NONE

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations 107  
Of autopsy \_\_\_\_\_

MOTHER FATHER { 11. Industry or business NONE

12. Name UNKNOWN

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

14. Maiden name Unknown

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

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? \_\_\_\_\_

16. (a) Informant Supervisor County Home

(b) Address Bloomfield Mo

17. (a) Burial (b) Date thereof FEB 20 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation County Home Cemetery

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 0

23. Signature Dr. J. Harris (M. D. or other) MD  
Address Bloomfield Mo Date signed 20 19 1946

18. (a) Signature of funeral director Jess Berlin

(b) Address Bloomfield Mo

19. (a) 2/20/46 (b) Pearl Gluon  
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Office No. 2,  
District File Number 346-335

Date Filed 3/6/46

**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. max  
Registrar's No. \_\_\_\_\_

Registration District No. 338 Primary Registration District No. (6/48)

1. PLACE OF DEATH:  
(a) County Stoddard  
(b) City or town Bloomfield (Rural, Castor)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Stoddard County Home  
(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 \_\_\_\_\_ (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 \_\_\_\_\_

3. (a) PRINT FULL NAME May 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 S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 82 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) Rose Wilber  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

8235