

Registration District No. 157

Primary Registration District No. 4248

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: 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 41 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper ⁴⁹

(c) City or town Sarcoxie Mo
(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 Abie Johnson

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16th
year 1947 hour 8 minute 55 P. M.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Edward T 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 2 - 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 15, 1947, to Feb 16, 1947;
that I last saw her alive on Feb 15, 1947;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>10</u>	<u>14</u>	hr. _____ min. _____

Immediate cause of death: Myocarditis Chronic Nephritis Chronic
Duration 10 yrs 10 yrs

9. Birthplace Mt. Vernon Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

Due to _____

Due to _____

Other conditions senility
(Include pregnancy within 3 months of death)

MOTHER FATHER

12. Name John Willmore

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

14. Maiden name Sarah Jane Page

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

Major findings: Of operations 13 10

Of autopsy _____

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

16. (a) Informant Mrs. Clair Davis
(b) Address KC Mo

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

(c) Place: burial or cremation Carl Junctions

18. (a) Signature of funeral director Jackson & Son
(b) Address Sarcoxie Mo

19. (a) 2-18-1947 (b) D. B. Clinton M.D.
(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? _____

While at work _____ (Specify type of place)
(a) _____ (b) _____ Means of injury 0

23. Signature Georgette Wood (M. D. or _____)
Address Carthage Mo Date signed 18 Feb 47

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

+7-2-123

DEC 18 1987

BBBI 67 700

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 me

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

Signed Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Larocque 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.