

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9925

U.S. No. 2
FORM 5-43
Rev. 5-17-39
X38871

FILED MAR 25 1947

Registration District No. 2

Primary Registration District No. 5728

Registrar's No. 165

1. PLACE OF DEATH:
(a) County MACON
(b) City or town ANABEL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Round Grove Twship 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 yrs. (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Mary Catherine Johnston
(b) If veteran, name war ✓
(c) Social Security No. ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 21 year 1947 hour 17 minute 45 P.M.
21. I hereby certify that I attended the deceased from Feb 2 1947 to Feb 21 1947
that I last saw her alive on Feb 21 1947 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife James Johnston 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased: March 28 1862
(Month) (Day) (Year)

Immediate cause of death: Fracture of Right hip Duration Today

8. AGE: Years 84 Months 10 Days 23 If less than one day hr. _____ min. _____

Due to _____
Due to _____

9. Birthplace ILL 1 (City, town, or county) (State or foreign country)
10. Usual occupation House wife

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

11. Industry or business _____
12. Name Washington Hartgrove
13. Birthplace Ky 1 (City, town, or county) (State or foreign country)
14. Maiden name Mary Johnson
15. Birthplace ILL 1 (City, town, or county) (State or foreign country)

Major findings: 1816
Of operations _____
Of autopsy _____

16. (a) Informant Lewis King
(b) Address Moberly, Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 2-24-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Cross Chapel

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 61
(b) Date of occurrence Feb 2 1947
(c) Where did injury occur? Anabel, Macon Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Her home, slipped and fell in 1st floor (Specify type of place)
While at work? yes (e) Means of injury Fall

18. (a) Signature of funeral director C. E. Loper
(b) Address Clareville, Mo
19. (a) 3-10-47 (Date received local registrar) (b) Wm Mcneely (Registrar's signature)

23. Signature D. L. Harlan MD (M. D. or other) Address Clareville, Mo Date signed Feb 24 1947

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

RECEIVED
District Health Officer No. 10
District File Number 3-47-544
Date Filed MAR 24 1947

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..... *Louis E. Hopper*
Licensed Embalmer No..... *4261*
P. O. Address..... *Clarence, 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.