

No. 2  
-12-45  
-17-39  
X47070

FILED SEP 2 1947

State File No. \_\_\_\_\_

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 115

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Chillicothe  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 343 Wise. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 Weeks. (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston<sup>59</sup>  
(c) City or town Chula<sup>0</sup>  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No) D  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Nettie Rachel Johnson

3. (b) If veteran, name war L 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Joseph Johnson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 2 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 11 22 hr. min.

9. Birthplace Chillicothe Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name W. Melton Johnson

13. Birthplace Ill. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah

15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Johnson

(b) Address Chula MO

17. (a) Burial (b) Date thereof Aug. 26 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plainview Cemetery

18. (a) Signature of funeral director E. Robertson Funeral Home

(b) Address Chula MO.

19. (a) Aug 25 1947 (b) Francis B Neill  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24  
year 1947 hour 12:45 minute PM

21. I hereby certify that I attended the deceased from Aug 10  
21 1946, to Aug 27 1946,  
that I last saw her alive on Aug 25 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation 24 yrs  
Duration \_\_\_\_\_

Due to Arterial Sclerosis 10 yrs

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? \_\_\_\_\_

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

23. Signature Joseph Conrad (M. D. or other) M.D.

Address Chillicothe, Mo Date signed Aug 25 47

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

MOTHER FATHER

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

**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

*John M. Robertson*

Licensed Embalmer No.

*4388*

P. O. Address

*Laredo 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.**