

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 5 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8217**  
Registrar's No. **15-**

Registration District No. **74**

Primary Registration District No. **4136**

1. PLACE OF DEATH:

(a) County **Clinton**  
(b) City or town **Plattsburg**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **S**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **68 yrs.**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clinton 25**  
(c) City or town **Plattsburg 3**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **0**  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **William Johnston ERWIN**

3. (b) If veteran, name war **A** 3. (c) Social Security No. **X**

4. Sex **MALE** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **JAN 2 1880**  
(Month) (Day) (Year)

8. AGE: Years **68** Months **2** Days **21** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Clinton Co. Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **SALESMAN**

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

12. Name **Joseph ERWIN**

13. Birthplace **Clinton Co. Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **LOUISA JOHNSTON**

15. Birthplace **Clinton Co. Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. Alford Niesler**

(b) Address **Plattsburg MO.**

17. (a) **Burial** (b) Date thereof **3 25 48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Plattsburg, MO.**

18. (a) Signature of funeral director **D. D. Lyon**

(b) Address **Plattsburg, MO.**

19. (a) **Mar 25-48** (b) **Becher Chatham**  
(Date received local registrar) (Registrar's signature) **297a**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **23**  
year **1948** hour **4** minute **P.** M.

21. I hereby certify that I attended the deceased from **Mar 22 1948** to **Mar 23 1948**;  
that I last saw him alive on **Mar 22 1948**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** *Immediate*

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations **none**

Of autopsy **none**

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) (e) Means of injury \_\_\_\_\_

23. Signature **W. B. Halding MD** (M. D. or other) **MD**

Address **Plattsburg MO**

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

15  
30

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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**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.....

*Danell N. Lyon*

Licensed Embalmer No. 3640

P. O. Address Plattsburg 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.