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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED NOV 1 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32059

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1107

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 218 Alabama St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 42 years (Specify whether years, months or days)
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

Missouri Buchanan //
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 218 Alabama St. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM D. JOHNSTON

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Maled 5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rosa 6. (c) Age of husband or wife if alive 80 years 1863 (Day) (Year)

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

8. AGE: Years 85 Months 6 Days 9 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business None

12. Name William Johnston

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

14. Maiden name Elizabeth Livingston (City, town, or county) (State or foreign country)

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

16. (a) Informant Rosa Johnston (wife)

(b) Address 218 Alabama St., City

17. (a) Burial (b) Date thereof 10/18/48 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director John E. Rupp

(b) Address 6054 Pryor Ave., City

19. (a) 10-25-48 (b) K. B. Jenkins (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month October 16, day 4, year 1948 hour 4 minute 35 P.M.

21. I hereby certify that I attended the deceased from Oct 6, 1948 to Oct 16, 1948 that I last saw him alive on Oct 16, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypo-static Pneumonia 2 days, Acute Myocarditis 6 days

Due to: Fracture Hip - Oct 5, 1948

Due to: Left Trochanteric fracture

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

Major findings: Of operations: 1860

Of autopsy: ADDITIONAL SUPPLEMENT INFORMATION REQUESTED

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 Dr. Ben Riles (M. D. or other) D.O. Address 6207 King Hill Cir. Signed 10-18-48

Duration

PHYSICIAN

Underline the cause to which death should be assigned statistically.

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

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.....

..... *Grandal R. Stabe* Registered Apprentice No. *213*
working under my personal supervision.

Signed..... *John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, 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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Wm D. Johnston
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased April 7 1881
(Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ (less than one day)
hr. _____ min. _____

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

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 _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 21. I hereby certify that I attended the deceased from _____
year 1944 hour _____ minute _____ M. 6

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. Duration
Immediate cause of death _____

Due to This man tripped & fell as he was about to enter his bed, in his own home.
Due to _____
Other conditions He tripped on a small throw rug
(Include pregnancy within 3 months of death)

Major findings: Senility & Chronic
Of operations _____
Of autopsy Heart disease are the contributory factors

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

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 _____

23. Signature Benjamin Rice, M.D. Date signed _____
Address _____

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

SUPPLEMENTARY

S-32059