

FILED OCT 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31320

State File No.

BIRTH NO. _____ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054 Registrar's No. 104

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u> <u>0 P. 2.0</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Louisiana</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>--Rural--Peno</u> <u>0</u>	
c. LENGTH OF STAY (in this place) <u>5 days</u>		d. STREET ADDRESS (If rural, give location) <u>RFD, Frankford, Missouri</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pike Co. Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>THOMAS</u> c. (Last) <u>JOHNSTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 22, 1950</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Feb. 14, 1870</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Fort Scott, Kans.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					

13a. FATHER'S NAME <u>J. C. Johnston</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Jackson</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Mae Johnston, RFD, Frankford, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hard of plaque</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>157X</u>

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1944, to 9-22, 1950, that I last saw the deceased close on 9-22, 1950, and that death occurred at 7:25 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Louisiana, Missouri</u>		23c. DATE SIGNED <u>9/22/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/24/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Frankford Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Frankford, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>Sept 23, 1950</u>		REGISTRAR'S SIGNATURE <u>Berniece Collier</u> <u>374</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sterne Funeral Home, Louisiana, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 4 1951

Date Received: SEP 29 1950
DISTRICT HEALTH OFFICE
District File Number 9-5
Date Filed: SEP 29 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Virginia M. Steene*

Licensed Embalmer No. *4645*

P. O. Address *Louisiana, 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.