

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

32475
Do not use this space.

DESD OCT 17 1939

1. PLACE OF DEATH

(a) County Henry co. Registration District No. 347
 (b) Township Beaumont Creek Primary Registration District No. 3018
 (c) City Clinton (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

JOHN ERVIN JOHNSTON

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adella Plew Johnston
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 12, 1856
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 82 9 11
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. minister (Retired)
 9. Industry or business in which work was done, as saw mill, bank, etc. Presbyterian Church
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-23 1939
 22. I HEREBY CERTIFY, That I attended deceased from 9-21- 1939 to 9-23 1939
 I last saw him alive on 9-25 1939. Death is said to have occurred on the date stated above, at 11:30 A.M.
 The principal cause of death and related causes of importance were as follows:

acute gastro enteritis.
10 hr
 Other contributory causes of importance: Pneumonia (terminal)
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? NO
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Antwerp Ohio
Werners County

FATHER 13. NAME Thomas Johnston
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Deland

MOTHER 15. MAIDEN NAME Sara Bourland Keel
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington, Pa

17. INFORMANT (ADDRESS) Mrs. Roy Graham
1915 No. Broadway Albuquerque

18. BURIAL, CREMATION, OR REMOVAL PLACE Clinton Mo. DATE 9-25

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leann & Leann
Montrose Mo

20. FILED 10-2 39 Dr J R Hampton Local Registrar

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____ (Signed) Joseph B. Pearl M. D.
 (Address) Clinton, Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

SDM-1-12-38 I X14023

RECEIVED

District Health Officer No. 7,

District File Number 1-39-1373

Date Filed 10-7-39

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,

..... for by

Registered Apprentice No., working under my personal supervision.

Signed

Oscar Eschoff

Licensed Embalmer No.

3943

P. O. Address

Appleton Ct. 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, above space should be left blank.