

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.

FILED APR 8 1940

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Henry
 (b) City or town Clinton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
North 2nd St. Clinton
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 2 mo
 years, months or days) _____ (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Henry
 (c) City or town Clinton
 (If outside city or town limits, write "RURAL")
 (d) Street No. 901 7 2nd St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Marguerette Johnson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 2 day 29
 year 1940 hour 8:00 minute _____ A. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased. Oct 22 1855
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
84 4 7 hr. _____ min.

Immediate cause of death: Death apparently due to Unknown Cause
 Duration Unknown

9. Birthplace Indianapolis Indiana
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name Samuel Smuck
 13. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Mr Joe Hayes
 (b) Address Supervisor mo
 17. (a) burial (b) Date thereof 3 1 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Congwood Cem.
 18. (a) Signature of funeral director Fred C. Wilkinson
 (b) Address Clinton Mo
 19. (a) 3-9-40 (b) Dr. R. C. Hampton
 (Date received local registrar) (Registrar's signature)

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?
3/2 (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature S. C. Hughes (M. D. or other) _____
 Address Corners Hwy of Clinton, Mo Date signed 3/1/40

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 Rich Wilkerson

Licensed Embalmer No. 2478

P. O. Address Clinton, 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.