

FILED MAY 1, 1947

Registration District No. **137**

Primary Registration District No. **3023**

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

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: **at home on water st 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: **Life**
(Specify whether years, months or days)

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.: **7 water**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: **Laura Johnson**

3. (b) If veteran, name war: **✓**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **april** day **22** year **1947** hour **3:10 PM** M.

4. Sex: **Fe** 5. Color or race: **w**

6. (a) Single, widowed, married, divorced: **married**

6. (b) Name of husband or wife: **Carmelia**

6. (c) Age of husband or wife if alive: **46** year

7. Birth date of deceased: **5-29-1900**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1/1/46** to **April 22 1947**
that I last saw her alive on **April 22 1947** and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of Cervix** Duration: **18 mo**

8. AGE: Years **36** Months **10** Days **23** If less than one day _____ hr. _____ min.

Due to: **(2) Recto-vesico-vaginal fistula**

Due to: **(3) Left pyopneumothorax**

Due to: **(4) Myocardial infarction**

Other conditions: **pneumonia**

(Include pregnancy within 3 months of death)

9. Birthplace: **Clinton Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Housewife**

Major findings: **autopsy report**

Of operations: **Plumb A. Acherman M.D.**

Of autops: _____

PHYSICIAN: **Plumb A. Acherman M.D.**

11. Industry or business: _____

12. Name: **Wm J. Bailey**

13. Birthplace: **Kans**
(City, town, or county) (State or foreign country)

14. Maiden name: **Alma Corner**

15. Birthplace: **Clinton Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Carmelia Johnson**

(b) Address: **Clinton Mo**

17. (a) **Burial** (b) Date thereof: **4-25-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Swinging Creek**

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? **No**

While at work? _____ (Specify type of place)

Means of injury: _____

23. Signature: **R. J. Powell** (M. D. or other) Date signed: **4/24/47**

Address: **Clinton Mo**

18. (a) Signature of funeral director: **Fred W. Beckman**

(b) Address: **Clinton Mo**

19. (a) **4-24-47** (b) **R. R. Kenney**
(Date received local registrar) (Registrar's signature)

MAY 8 1947

RECEIVED
District Health Officer No. 7
3-47-509
District File Number
4-28-47
Date Filed

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.....

Fred Wilkinson Jr.

Registered Apprentice No. ~~434~~ 434

working under my personal supervision.

Signed *Fred Wilkinson*

Licensed Embalmer No. *2487*

P. O. Address *Clinton Ma*

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.