No. 300
-10-47
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 14 1948

Registration District No. 937

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3023

State File No. 26068

Registrar's No. 184

WRITE PLAINLY—USE 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: Clinton Genl Hospt 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 weeks (Specify whether years, months or days)
In this community All life

2. USUAL RESIDENCE OF DECEASED: 42
(a) State Mo (b) County Henry
(c) City or town Blairstown Mo 0 (If outside city or town limits, write "RURAL")
(d) Street No. R.R. #3. 0 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Margret Jane Johnston
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced widow 2
6. (b) Name of husband or wife W. W. Johnston
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 1 (Day) 1875 (Year)

8. AGE: Years 73 Months 4 Days 3 If less than one day hr. min.

9. Birthplace Blairstown (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation House work
11. Industry or business

FATHER
12. Name John Lotspiech 9
13. Birthplace unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Caroline Potts 1
15. Birthplace North Carolina State (City, town, or county) (State or foreign country)

16. (a) Informant Geraldine Bloomlost
(b) Address Clinton Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-48 (Month) (Day) (Year)
(c) Place: burial or cremation Blairstown Mo
18. (a) Signature of funeral director Consalus & Peck
(b) Address Clinton Mo
19. (a) 9-14-48 (Date received local registrar) (b) R R Kenney (Registrar's signature) 720

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 4 year 48 hour minute 2 P M.

21. I hereby certify that I attended the deceased from 6-11, 1948 to 9-4, 1948; that I last saw her alive on 9-4, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	1 wk
Due to Fractured Hip	6 wks
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

ADDITIONAL 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)
While at work? (e) Means of injury

23. Signature H. S. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 9-4-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 8-48-1059
Date Filed 9-13-48

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 J. E. Conroley

Licensed Embalmer No. 1891

P. O. Address Clinton N.C.

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.

No. 2B
M—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept 5

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 184

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Margaret J. Johnston

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 1 (Month) (Day) (Year)
8. AGE: Years 73 Months 4 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4 year 1948 hour minute M.
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.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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

1810 / 4 / 1

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 7-22-48
(c) Where did injury occur? Clinton (City or town) Henry (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home slipped & fell on floor (Specify type of place)
While at work? (e) Means of injury Fractured femur
23. Signature J. L. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 9-17-48

SUPPLEMENTARY

S- 26068 1948