

FILED MAY 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17223

17223

Registration District No. 732

Primary Registration District No. 4203

Registrar's No.

1. PLACE OF DEATH:

(a) County Grundy
(b) City or town Galt
(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)

3. (a) PRINT FULL NAME Margaret Ann Johnson

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased July 31 1868
(Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days 10 If less than one day hr. _____ min. 0

9. Birthplace Sullivan Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business House wife

12. Name John Duff
13. Birthplace Scotland
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Lowe
15. Birthplace Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant John Johnson
(b) Address Galt Mo.

17. (a) Burial (b) Date thereof 4-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Galt Old Cemetery
P.K. Payne & Son.

18. (a) Signature of funeral director _____
(b) Address Galt, Mo.

19. (a) 4/10/47 (b) Frank Dan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Grundy
(c) City or town Galt
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10 1947
year 1947 hour 2 minute 0 M.

21. I hereby certify that I attended the deceased from 1-1-30 to 4-10-47
that I last saw her alive on 4-9-47
and that death occurred on the date and hour stated above.

Immediate cause of death Organic heart disease
(Mitral regurg.) Duration ?

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) W.D.

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? C

(Specify type of place) _____
(e) Means of injury _____
23. Signature U.C. Westby M. D. of _____
Address 4-11-47 Galt, Mo. Date _____

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

MOTHER FATHER

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

P. K. Payne Jr.

Licensed Embalmer No.....

3400

P. O. Address.....

Galt

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.