

S. No. 2
M-843
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42269

State File No.

FILED JAN 2 1945

Registration District No. 388

Primary Registration District No. 4510

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Asgood
(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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan ¹⁰⁵

(c) City or town Asgood ⁰
(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 _____

3. (a) PRINT FULL NAME MRS. ELIZABETH FRANCES 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 Widow

6. (b) Name of husband or wife Ellie Johnson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 1 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>3</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Sullivan Co Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business _____

12. Name Ambrose Phipps

13. Birthplace Ill (City, town, or county) (State or foreign country)

14. Maiden name Fannie Mills

15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ray Hatcher

(b) Address Asgood Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Johnston Cem.

18. (a) Signature of funeral director DR Payne

(b) Address Galt Mo

19. (a) Dec. 28 1944 (Date received local registrar) (b) Brita Caldwell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1944 hour 3 minutes 55 P.M.

21. I hereby certify that I attended the deceased from 12-7-1944 to 12-19-1944 that I last saw her alive on 12-18-1944 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 15 da.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 108

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H.C. Weston (M.D. or D.V.M.)

Address Galt, Mo. Date signed 12-20-44

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

COM

1380

(Licensed Embalmer's Statement on Reverse Side)

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.....

PK 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.