FILED MAY 15 1940

. No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16195

Registration District No. 796 Primary Registration District No. 3038 Registrar's No. 57

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

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbons Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital ~~or institution~~ One Week (Specify whether

In this community all her life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Slater (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ollie Mae 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. (b) Name of husband ~~or wife~~ Ernest Ernest Johnson

6. (c) Age of husband ~~or wife~~ if alive 42 years

7. Birth date of deceased August 9 1885 (Month) (Day) (Year)

8. AGE: Years 54 Months 7 Days 22 If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name William Haynes
13. Birthplace Ross Co Ohio (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Carrie Alice Leach
15. Birthplace Dont Know Dont Know (City, town, or county) (State or foreign country)

16. (a) Informant Ernest Johnson

(b) Address Slater Mo

17. (a) Removal ~~(Burial, cremation, or removal)~~ (b) Date thereof 4-3-40 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Slater City Cemetery

18. (a) Signature of funeral director Jones & Salzer

(b) Address Slater Mo

19. (a) 4-3-40 (Date received local registrar) (b) Mary Kent Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1 year 1940 hour 7 minute 25 P M.

21. I hereby certify that I attended the deceased from March 16, 1940 to April 1, 1940 that I last saw her alive on April 1, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Nephritis. Cause unknown	3/28/40
Due to: Hysterectomy	3/26/40
Due to:	
Other conditions: Acute Myocarditis (Include pregnancy within 3 months of death)	3/28/40

Major findings: Of operations Uterine tumor — possibly Cancer. Of autopsy Not performed

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. A. McBurney (M. D. ~~or other~~)

Address Slater, Mo Date signed 4-2-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 5-14-40
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 ..... , Registered Apprentice No. ..... working under my personal supervision.

Signed J E Jones

Licensed Embalmer No. 3143

P. O. Address Slater 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.