

FILED MAY 6 1943 99

State File No. _____
Registrar's No. 110

Registration District No. _____ Primary Registration District No. 5380

1. PLACE OF DEATH:

(a) County De Kalb
(b) City or town Clarksville, Washington
(c) Name of hospital or institution home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Libe years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County De Kalb
(c) City or town Clarksville, Rural
(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 APR day 26
year 1943 hour 6 minute 00 A.M.
21. I hereby certify that I attended the deceased from
viewed the body
and that death occurred on the date and hour stated above.

Immediate cause of death
CHRONIC MYOCARDITIS

Due to _____
Due to _____

Other conditions
(Include pregnancy within 3 months of death) 93d

Major findings:
Of operations _____
Of autopsy NONE

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 Ruth E. Riedel (M. D. or other) Do,
Address Union Springs, Mo. Date signed 4-26-43

3. (a) PRINT FULL NAME SALLIE F. JOHNSON
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female / 5. Color race
6. (a) Single, widowed, married, divorced, widower
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive, years
7. Birth date of deceased 12 20 1871 (Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 6 If less than one day hr. min.

9. Birthplace Buchanan co mo (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Poore
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Mary Powell
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Cara Davis
(b) Address Easton mo

17. (a) Burial (b) Date thereof 4-30-43 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Union Chapel

18. (a) Signature of funeral director John O. Brown
(b) Address _____

19. (a) Date received by registrar 5-1-43 (b) Registrar's signature M. O. Wingle (Registrator's signature)

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

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

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

John G. Brown

Licensed Embalmer No. *3933*

P. O. Address

Maysville, 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, fact should be so stated above.