. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5591

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 128

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6215 Sherman St. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 years (Specify whether
In this community 31 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 6215 Sherman St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Nellie Rose Johnson
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ira
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased February (Month) 4, (Day) 1875 (Year)

8. AGE: Years 69 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Lamoni, (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Home
FATHER
12. Name John Argabright
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Love Ann Patrick
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Ira Johnson (Husband)
(b) Address 6215 Sherman St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery
18. (a) Signature of funeral director John E. Kupp
(b) Address 6054 Pryor Ave., City
19. (a) 2-5-45 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3, year 1945 hour 10 minute 00 A.M.
21. I hereby certify that I attended the deceased from 1/27, 1945, to 1/3, 1945; that I last saw her alive on 2/1/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage 7 Dec
Gen Arteriosclerosis Unknown
Due to Chr Hypertension Unknown
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 8 3 a
Of autopsy

Duration

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 [signature] (M. D. or other)
Address 234 Ice Ave Date signed 2/07/46

1377 (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 John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St Joseph

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.