FILED DEC 31 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

45426 STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6021 Registrar's No. 150

1. PLACE OF DEATH
a. COUNTY Ray
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Grape Grove rural — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home — Length of stay in 1b 2m

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Iowa b. COUNTY Cedar
c. CITY OR TOWN Mechanicsville — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) 910 S — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First William Middle Samuel Last Johnston

4. DATE OF DEATH: Month I2 Day 27 Year I957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 2-I9-I872

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (City and state or country): Hopkinton, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME: Alexander R. Johnston

13b. MOTHER'S MAIDEN NAME: Elizabeth Guthrie

14. NAME OF HUSBAND OR WIFE: Charlottee Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mrs. Carl Fehlman, Cowgill, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH 4 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility 331X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11-10-57 to 12-27-57 and last saw her/him alive on 12-26-57
Death occurred on 12-27-57 8:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. Darnell M.D. — 22b. ADDRESS Richmond — 22c. DATE SIGNED 12-28-57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal — 23b. DATE I2-31-1957 — 23c. NAME OF CEMETERY OR CREMATORY Hopkinton Cemetery — 23d. LOCATION (City, town, or county) (State) Hopkinton, Iowa

24. FUNERAL DIRECTOR ADDRESS: Cramer Clark, Kingston, Missouri

25. DATE RECD. BY LOCAL REG. 12-28-1957

26. REGISTRAR'S SIGNATURE Maud Jackson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

. Health, & Welfare . Public h Service

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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 ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Cramer Clark

Licensed Embalmer No. 3257

P. O. Address Kingston

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.