MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Dunklin

Township: _____ or Village: _____ or City: Malden (NO. _____, _____ St.; _____ Ward)

Registration District No. 289 File No. 27528

Primary Registration District No. 4173 Registered No. 106

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Elsie Marie Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE – MARRIED – WIDOWED – OR DIVORCED (Write the word)

DATE OF BIRTH: Jan. (Month) 1 (Day), 1911 (Year)

AGE: 10 yrs. 10 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

BIRTHPLACE (City or town, State or foreign country): Malden Mo.

PARENTS

NAME OF FATHER: Leslie M. Johnson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Saline County Ills.

MAIDEN NAME OF MOTHER: Lula A. Clark

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Saline County Ills.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie M Johnson

(ADDRESS) Malden Mo.

Filed 11-28, 1911. S. S. Mitchell, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov. (Month) 27 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 18, 1911, to Nov. 20, 1911, that I last saw her alive on Nov 20, 1911, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

87B

(Duration) ___ yrs. 5 mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) George Dalton M. D.

Nov. 28, 1911 (Address) Malden Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Malden Mo.

DATE OF BURIAL: 11-28, 1911

UNDERTAKER: W. L. Craig

ADDRESS: Malden Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____; _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), *1*____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), *191*____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____; and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.