N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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: Cooper

Township: ~~Saline~~

or Village: Wooldridge

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

Registration District No.: 225

Primary Registration District No.: 4438

File No.: 9321986-a

Registered No.: 3

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

FULL NAME: Walter Arnold Johnson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: July (Month) 23 (Day), 1902 (Year)

AGE: 12 yrs. 11 mos. 23 ds.

If LESS than 1 day, 5 hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): _____

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

PARENTS

NAME OF FATHER: Scott P. Johnson

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

MAIDEN NAME OF MOTHER: Rosa A. Rimel

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Gussie Wolfe

(ADDRESS): Overton Mo

Filed July 17, 1915 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 16 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from July 1, 1915, to July 16, 1915, that I last saw him alive on July 16, 1915, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ___ yrs. 01 mos. 16 ds.

Contributory (SECONDARY): None

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

(Signed) W Roberts M. D.

July 17, 1915 (Address) Wooldridge 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: Cooper Cmt Mountain Co

DATE OF BURIAL: July 17, 1915

UNDERTAKER: K. D. Mason

ADDRESS: Overton Mo

Revised United States Standard Certificate

MISSOURI STATE BOARD OF HEAI
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 occurr hospital or inst give its NAME of street and num

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

....., 1.....
(Month) (Day) (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

....., 1
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 19

that I last saw h.....alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 19
UNDERTAKER	ADDRESS