LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

V. S. No. 2.

Preliminary

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 39009

Duplicate of 42 39008

1 PLACE OF DEATH

County Ozark

Township Big creek Registration District No. ..... File No. .....

or

Village ~~Huggins ville~~ Primary Registration District No. 5858 Registered No. 1

or

City ..... (NO. ..... St.; ..... Ward)

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

2 FULL NAME Dass Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

6 DATE OF BIRTH Sept (Month) 27 (Day) 1917 (Year)

7 AGE ..... yrs. 1 mos. 25 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer) none

9 BIRTHPLACE (City or town, State or foreign country) Duggins ville Mo

PARENTS

10 NAME OF FATHER John Calvin Johnson

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

12 MAIDEN NAME OF MOTHER Bessie Francis Futrell

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John C. Johnson

(Address) Huggins ville Mo

15 Filed Dec 31, 1917 Mary F. Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 21 (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from No Medical aid, 1917

that I last saw h..... alive on ....., 191....

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

159 Premature Birth

151 Exposure to Mother

(Duration) ..... yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) John C. Johnson M. D.

Dec 31, 1917 (Address) Duggins ville Mo

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. 1 mos. 25 ds. In the State ..... yrs. 1 mos. 25 ds.

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Lutie Cemetery

DATE OF BURIAL Nov 24, 1917

20 UNDERTAKER Joe Futrell

ADDRESS Theodosia Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF (

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... , ... St.: ..... Ward)

(If de
hospital
give its
of stree

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

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

7 AGE

.....yrs.....mos.....ds.

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day)

17 I HEREBY CERTIFY, that I attended dec

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

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

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 C
(1) Means of Injury; and (2) whether Accidental, Suicidal or H

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, T
or 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 .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL**

20 UNDERTAKER | **ADDRESS**

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite);