

1 PLACE OF DEATH

County Franklin
 Township Salun
 or
 Village
 or
 City

Registration District No.

Primary Registration District No.

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

File No.

Registered No.

12728

290

5208

437

(NO

St.

Ward)

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

2 FULL NAME

Mary Colala Johnson

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 2 19 1918
 (Month) (Day) (Year)

7 AGE : If LESS than 1 day.....hrs. or.....min.?
Yrs. One 1 19 ds.

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) Franklin County MO

PARENTS

10 NAME OF FATHER Greenfield Johnson

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

12 MAIDEN NAME OF MOTHER Charity Shaver McKinnon

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Greenfield Johnson
 (Address) Senath Mo

15 Filed 5-7 1918 W. M. B. ...
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 4 1918
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from there was no attendance of 191
Physician that I last saw h. 191
 and that death occurred, on the date stated above, atm.
 The CAUSE OF DEATH* was as follows:

No attendance of Physician

205 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) W. H. Hughes M. D.
8 W V 1918 (Address) Senath Mo

*State the Disease Causing Death, or, in death 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. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Senath Cemetery DATE OF BURIAL May 7 1918

20 UNDERTAKER C. M. Daniel ADDRESS Senath Mo

Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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

1 PLACE OF DEATH

St. Louis
Salon

Registration District No. *290*

File No.

Primary Registration District No. *5408*

Registered No. *437*

(NO. _____)

St. _____

Ward _____

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

L NAME

Mary Orla Johnson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

4 COLOR OR RACE

W

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

S

16 DATE OF DEATH

4-18
(Month) (Day) 191 (Year)

DATE OF BIRTH

(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from

191 to 191

that I last saw him alive on 191

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

The CAUSE OF DEATH* was as follows:

Not Known

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. J. [Signature]* 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.

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

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19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20 UNDERTAKER

ADDRESS

I HAVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature)

(Address)

8-30 191 *F. H. [Signature]*

Registrar

Satisfactory Information Supplied.

ON profession, or other kind of work

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

PLACE OF BIRTH

(Country)

NAME OF FATHER

PLACE OF BIRTH FATHER

(City or town, State or foreign country)

IDENT NAME MOTHER

PLACE OF BIRTH MOTHER

(City or town, State or foreign country)

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

82121

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