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

1 PLACE OF DEATH

County: Dunklin

Township: Cotton Hill or Village: ..... or City: ..... (NO. ..... St.: ..... Ward)

Registration District No. 289 File No. 22893

Primary Registration District No. 3407 Registered No. 71

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

2 FULL NAME S. H. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: X July (Month) 19 (Day) 1867 (Year)

7 AGE: 60 yrs. 11 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): X Savonah Tenn.

PARENTS

10 NAME OF FATHER: X Henderson Johnson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): X Know not

12 MAIDEN NAME OF MOTHER: X Know not

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): X Know not

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Johnson

(Address) Malden Mo

15 Filed 7-10, 1918. S. E. Mitchell, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 9 (Day), 1918 (Year)

17 I HEREBY CERTIFY that I attended deceased from Suicide, 191..., to Suicide, 191..., that I last saw h..... alive on Suicide, 191..., and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:
Gunshot Wound inflicted by his own hand (Suicide)

1867 51 (Duration) 0 yrs. 0 mos. 0 ds.

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

(Signed) A. A. Little acting coroner ~~M. D.~~

July 10, 1918 (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.

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: Malden Mo. DATE OF BURIAL: 7-11, 1918

20 UNDERTAKER: F. L. Craig ADDRESS: Malden Mo.

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.

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

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1 PLACE OF DEATH

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Township ..... or

Village ..... or

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

2 FULL NAME .....

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

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 .....

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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), 191..... (Year)

17 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) .....

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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

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS

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