LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

1641

1. PLACE OF DEATH
County: New Madrid — Registration District No. 55 — File No. 2
Township: [illegible] — Primary Registration District No. 4033 — Registered No. 175
City: Jefferson (No. ..... St. ..... Ward)

2. FULL NAME: Marie Anna Johnson

(a) Residence. No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~Single~~, Married, ~~Widowed~~ or Divorced (*write* the word)

5A. If Married, Widowed, or Divorced
HUSBAND of (or) WIFE of: Tom N. Johnson

6. DATE OF BIRTH (Month, day and year): Sept-14th 1881

7. AGE: Years: 40 — Months: 4 — Days: 10 — If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ~~Housewife~~
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9. BIRTHPLACE (City or town) ..... (State or country) Crittenden Co. Ky.

PARENTS
10. NAME OF FATHER: Joe Johnson
11. BIRTHPLACE OF FATHER (City or town) ..... (State or country) Crittenden Co. Ky.
12. MAIDEN NAME OF MOTHER: Angeline Nickels
13. BIRTHPLACE OF MOTHER (City or town) ..... (State or country) Lowell Co. Ky.

14. INFORMANT: M. Johnson
(Address): Jefferson

15. FILED Feb 10 1921 — M. V. Munroe, Registrar

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month, day and year): Jan 28 1921

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1921, to Jan 28 1921, that I last saw h. alive on Jan 28, 1921, and that death occurred, on the date stated above, at 3 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
(duration) 1 yrs. 10 mos. 7 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED ——
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No — DATE OF ——
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ——
(Signed) J. H. Cochran, M. D.
Jan 29, 1921 (Address) Jefferson Mo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Gullian — DATE OF BURIAL: 1/29 1921

20. UNDERTAKER: J. H. Crews — ADDRESS: Jefferson Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

**1. PLACE OF DEATH**

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

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

City..... (No..... ..... St. ..... Ward)

**2. FULL NAME** .....

(a) Residence. No..... St., ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| | | |

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min. |
|---|---|---|---|---|
| | | | | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

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