MC078

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

Do not use this space. 8316

1170

File No. .....

Registered No. .....

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Kaw — Primary Registration District No. .....

City Kansas City (No. Old City Hosp St. ..... Ward)

2. FULL NAME Clara E. Johnson

(a) Residence. No. Old City Hospital 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: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

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

7. AGE: 22 YEARS — MONTHS: 11 — DAYS: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student Nurse

(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): Ala.

PARENTS

10. NAME OF FATHER: J. W. Johnson

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

12. MAIDEN NAME OF MOTHER: Unknown

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

14. INFORMANT: Dr. H. M. Smith
(Address) Old City Hosp.

15. FILED 3/19, 1927 M. McCrone asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): 3-17-1927

17. I HEREBY CERTIFY, That I attended deceased from 3-10-, 1927, to 3-17-, 1927 that I last saw her alive on 17th March, 1927, and that death occurred, on the date stated above, at 4:05 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: General Peritonitis - following appendiceal abscess with Rupture. (Colon Bacillus in origin)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 117B 121C 123C 129

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3-15-27

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings & Lab.

(Signed) Howard M. Smith, M.D.

3-17-1927 (Address) Old City Hospital

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Highland Cem. — DATE OF BURIAL: 3-19-1927

20. UNDERTAKER: H. B. Moore Und. — ADDRESS: 1820 E 18th St

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.

...ADING INK—THIS IS A PERMANENT RECORD