

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

Do not use this space.

22807

**1. PLACE OF DEATH**

County.....  
Towship.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**

File No.....  
Registered No. **6467**  
St. .... Ward

**2. FULL NAME**

(a) Residence. No. **719 N. 7th St. 25** Ward.  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **11** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Male** | 4. COLOR OR RACE **negro** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 7, 1907**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**19 | 9 | 8**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **porter**  
(b) General nature of industry, business, or establishment in which employed (or employer) **-**  
(c) Name of employer **-**

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

10. NAME OF FATHER **Jimm Johnson**

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

12. MAIDEN NAME OF MOTHER **Courmond**

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

14. INFORMANT **Mrs. F. Woodard**  
(Address) **City Hospital #2**

15. FILED **11 15 1927** **Marie Starkeff**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 9 1927**

17. I HEREBY CERTIFY, That I attended deceased from **June 22**, 19**27**, to **July 8**, 19**27**, (that I last saw him alive on **July 8 1927**, and that death occurred, on the date stated above, at **4:30 P.M.**)

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Pulmonary tuberculosis**  
**23A**

**independent** (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **31** (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? **not known**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**  
(Signed) **W. S. Howell**, M. D.  
, 19 (Address) **City Hospital #2**

\*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 **Removed** (DATE OF BURIAL) **July 16 1927**

20. UNDERTAKER **J. S. Thomas** ADDRESS **3114 Loc**

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.

10/10/10  
10/10/10  
10/10/10