

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

Do not use this space.

23244

1. PLACE OF DEATH

County.....*St. Louis* Registration District No. *791* File No. *6941*
 Township..... Primary Registration District No. *1003* Registered No. *6941*
 City.....*4043 Finney Cr.* St. Ward.....

2. FULL NAME

(a) Residence. No. *4043 Finney Cr.* St. *11* 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 *Black* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 17, 1927*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
13

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *None*
 (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)
St. Louis Missouri

10. NAME OF FATHER *James J. Johnson*

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

12. MAIDEN NAME OF MOTHER *Bertha Hill*

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

14. INFORMANT *James J. Johnson*
 (Address) *4043 Finney Cr.*

15. FILED *409 - 1 1927* *May 6* *Sturkeoff*
 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 30, 1927*
 17. I HEREBY CERTIFY, That I attended deceased from *7-17-1927*, to *7-30-1927*, that I last saw him alive on *7-30-1927*, and that death occurred, on the date stated above, at *8:15 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sclerosis

CONTRIBUTORY *Obstruction of bile ducts*
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, *at place of death*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *None*
 (Signed) *Dr. William Johnson*
8-1-1927 (Address) *4039a Finney*

*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 *Buried* DATE OF BURIAL *July 1927*

20. UNDERTAKER *Wm. Johnson* ADDRESS *4039a Finney*

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.

THIS IS A MANEN

100

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 791

File No. 23244

Township.....

Primary Registration District No. 1003

Registered No. 6941

City St. Louis (No.)

St. Ward)

2. FULL NAME

Adrey Cox

(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 M 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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 (duration) yrs. mos. ds.
(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)

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 22 19 May 6 St. Louis off
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 30 1927

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Sepsis
Obstruction of bile duct
Cause unknown
given over phone by Dr. K. W. Johnson
160

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. W. of W.D. 11-9-27

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHY TEST CONFIRMED DIAGNOSIS?

(Signed) 160, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

THIS IS A SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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