

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

Do not use this space.

25826

1. PLACE OF DEATH

County..... Registration District No. **791** File No.....
 Township..... Primary Registration District No. **1003** Registered No. **7435**
 City *St Louis* (No. *4015 Ohio ave*) St. Ward.....

2. FULL NAME

Alice V. Johnstone
 (a) Residence. No. *4015 Ohio* St. *24* Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *45* 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*) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Chas W. Johnstone*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 9 - 1858*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 | *10* | *9*

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Marion*
 (STATE OR COUNTRY) *Illinois*

PARENTS

10. NAME OF FATHER *George W. Evans*

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

12. MAIDEN NAME OF MOTHER *Mariam Frances*

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

14. INFORMANT *Charles W. Johnstone*
 (Address) *4015 Ohio av*

15. FILED *618* *Mar 6 Stark off*
 No. 19.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8/18/27*

17. I HEREBY CERTIFY That I attended deceased from *7/10/27*, 19*27*, to *8/18/27*, 19*27* that I last saw her alive on *8/17/27*, 19*27*, and that death occurred, on the date stated above, at *8 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pernicious Anemia

CONTRIBUTORY (SECONDARY) *5805*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....

WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical Examination*

(Signed) *H. Hoffman* M. D.
 (Address) *8/18/27 3958 S. Grand*

*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.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary Cemetery*
 DATE OF BURIAL *8/20 1927*

20. UNDERTAKER *Joseph Meyer LLC*
 ADDRESS *603 Park Ave*

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.

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