

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

Do not use this space.

28060^a

NOV 28 1927

1. PLACE OF DEATH
 County Polk Registration District No. 708
 Township McKinley Primary Registration District No. 5927B-5
 City (No.) St. Ward

2. FULL NAME John H. Johnson
 (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 male 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 Emily J. Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 30-1853

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	74	5	28	5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Wm. Johnson

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

12. MAIDEN NAME OF MOTHER Laura Ann McKinley

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

14. INFORMANT Mrs. V. H. Greenwood
 (Address) Buffalo Mo.

15. FILED Sept 29, 1927 J. K. Roberts
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 28 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1927, to , 19 , that I last saw him alive on Sept 25, 1927, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
was diabetes mellitus on the onset
But had periph. capils on the feet

CONTRIBUTORY (SECONDARY)
 (duration) 2 yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) B. F. Johnson, M. D.
Sept 29, 1927 (Address) Buffalo 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Schofield Co. DATE OF BURIAL Sept 29 1927

20. UNDERTAKER Hutchison Blue ADDRESS Bolivar Mo.

State Board of
Education

State Board of
Education

State Board of
Education

Wm. H. ...
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

EXACTLY. PHYSICIANS should be c. y supplied. AGE should be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.

County Polk Registration District No. 708 File No. _____
 Township McKenley Primary Registration District No. 5937B Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME John H. Johnson

(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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 30 - 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

74 | 5 | 28 | _____ | _____

8. OCCUPATION OF DECEASED

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

(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) Mo

10. NAME OF FATHER Wm Johnson

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

12. MAIDEN NAME OF MOTHER Sarah Ann McKenney

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 28 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Was diabetes mellitus

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) B. F. Johnson - M. D. , 19____ (Address) Buffalo

*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.

14. INFORMANT Ms. U. H. Greenwood 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Schofield Cem DATE OF BURIAL Sept 29 1929
 (Address) Buffalo, Mo ADDRESS Bolivar

15. FILED _____ 19____ 9/30/29 20. UNDERTAKER Hutchison - Blue

X _____ REGISTRAR

SUPPLEMENTARY 57

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