

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

Do not use this space.

30994

**1. PLACE OF DEATH**

County Mississippi Registration District No. 576  
 Township Wolf Island Primary Registration District No. 576  
 City Wolf Island, Mo. (No. 5767) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 81

**2. FULL NAME**

Carrie Grew Johnson  
 (a) Residence. No. Pho. Sheeters Farm St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred about yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE Bl 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
about 43

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) Belmont Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Clara Grew

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER " "

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

14. INFORMANT X - P. Harlie Johnson  
 (Address) Wolf Island Mo.

15. FILED Oct 12 1927 W. A. Smith  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-13-27  
 17. 11:30 A.M.

I HEREBY CERTIFY That I attended Deceased from Oct 12, 1927 to Oct 13, 1927  
 that I last saw h. alive on Oct 12, 1927 and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Diphtheria

CONTRIBUTORY (SECONDARY) 10  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) Wesley W. Guter M. D.  
 10/13/27 (Address) Wolf Island 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 Belmont Cemetery DATE OF BURIAL 10-13-27

20. UNDERTAKER (Private) ADDRESS \_\_\_\_\_

Dr. W. H. Miller

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Mississippi Registration District No. 567 File No. \_\_\_\_\_  
 Township Wolf Island Primary Registration District No. 5767 Registered No. 73  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Carrrie Crews 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 <u>F</u>	4. COLOR OR RACE <u>B</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Charley Johnson</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE YEARS <u>alt 43</u>	MONTHS	DAYS
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at home -</u> (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)

**PARENTS**

10. NAME OF FATHER <u>Elisha Crews -</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER <u>Unknown</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)

14. INFORMANT Charlie Johnson  
 (Address) Wolf Island

15. FILED 12-10-27 Shuff on Hodges  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 - 19 27

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_, above on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Diphtheria

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) Geo. W. Whitaker, M. D.  
 . 19 (Address) East Prairie

\*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 \_\_\_\_\_

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-30994