1920

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

Do not use this space. 31241 a ~~30937~~

1. PLACE OF DEATH
County Ralls
Township Clay
City ~~Hannibal~~ (No. ..... St. ..... Ward)
Registration District No. 728
Primary Registration District No. 5961
File No. 8
Registered No. 327

2. FULL NAME John Johnson
(a) Residence. No. U B F Home 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 Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1842

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
85	—	—	

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

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

PARENTS
10. NAME OF FATHER No Record
11. BIRTHPLACE OF FATHER (CITY OR TOWN) —
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER No Record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) —
(STATE OR COUNTRY)

14. INFORMANT John Franklin
(Address) U. B. F. Home

15. FILED Oct 13, 1927 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 — 9 1927

17. I HEREBY CERTIFY, That I attended deceased from 6 45 pm Oct 8, 1927, to Oct 9, 1927 that I last saw him alive on Oct 8, 1927, and that death occurred, on the date stated above, at 6 25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
92 [illegible]
112 [illegible] (duration) — yrs. 1 mos. — ds.
CONTRIBUTORY (SECONDARY) Bronchial Asthma
— (duration) 2 or 3 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) O. C. Vreen, M. D
, 19 (Address) 1325 Lyon St.

*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 Robinson Cem
DATE OF BURIAL 10/12 1927

20. UNDERTAKER Geo E Roberts
ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 728

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH Palls
County Marion — Registration District No. 549 — File No. 8
Township — Primary Registration District No. 302-9396 — Registered No. 327
City Hannibal (No. ..... St. ..... Ward)

2. FULL NAME John Johnson
(a) Residence. No. U. B. F. Home 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.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: B
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt 1842

7. AGE: Years 85 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
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 John Franklin
(Address) U. B. F. Home

15. FILED Oct 3rd 1927 Marvin Hart
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 – 9 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1927, to Oct 9 1927 that I last saw h. alive on Oct 8 1927 and that death occurred, on the date stated above, at 6 45 pm 6 25 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Bronchial asthma

(duration) yrs. 1 mos. ds.

90N

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) O. E. Queen, M. D
, 19 (Address) 1325 ~~[illegible]~~ Lyon St

*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 Robinson Cem — DATE OF BURIAL 10 12 1927

20. UNDERTAKER Geo. E. Roberts — ADDRESS Hannibal Mo

5-31241a