

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

Do not use this space.

34533

**1. PLACE OF DEATH**

County St. Louis Registration District No. 784  
 Township W. Ferdinand Primary Registration District No. 18039  
 City So. Kinloch Park Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_

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

**2. FULL NAME**

M. J. Johnson  
 (a) Residence No. 57 Wackerney 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 9, 1926

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

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

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

10. NAME OF FATHER Mammel Johnson

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

12. MAIDEN NAME OF MOTHER Bessie Stewart

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

14. INFORMANT Mammel Johnson  
 (Address) 57 Wackerney St

15. FILED 11-12-1927 O. W. Shurtz  
 REGISTRAR

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

17. I HEREBY CERTIFY, That I attended deceased from 11/1 1927, to Nov 10 1927  
 that I last saw h. \_\_\_\_\_ alive on 9th Nov 1927, and that death occurred, on the date stated above, at 10 ds.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

10th Typhoid Fever  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 9 ds.

CONTRIBUTORY (SECONDARY) Bronchitis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) W. H. Jones, M. D.

(Address) Kinloch 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 Washington Park DATE OF BURIAL Nov 14 1927

20. UNDERTAKER R. M. C. Green ADDRESS 2517 Duclane

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.

JAN 6 1928

