

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

Do not use this space.
37547

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every word of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state every word of information.

W 1919

1. PLACE OF DEATH
 County Macon Registration District No. 547
 Township Macon Primary Registration District No. 3079
 City Hannibal (No. 109 North Maple ave St. 6 Ward)

2. FULL NAME Caskey Johnson
 (a) Residence, No. 506 Olive St. 1st Ward.
 (Usual place of abode) about (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 30 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 OR (OR) WIFE OF Florence Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 - 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
54 | 7 | 7 | |

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Wood Machinist
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer St. Louis & Hannibal R.R.

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

10. NAME OF FATHER Abel Johnson

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

12. MAIDEN NAME OF MOTHER Virginia Bagland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Florence Johnson, R.R.
 (Address) Hannibal, Mo.

15. FILED 1299-27 C. Estab
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 8 - 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tubercular Heart Disease

92A 90A
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Chas. R. Scott Coroner
1927 Marion Corcoran

*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 St. River Cemetery DATE OF BURIAL 12/10 - 1927

20. UNDERTAKER Schwartz Funeral Home ADDRESS Hannibal

