30 6734

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

Do not use this space.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 33570
Township Kaw — Primary Registration District No. 1002 — Registered No. [illegible]
City KC (No. Vineyard Park Hospital Ward)

2. FULL NAME Emma Johnson
(a) Residence. No. 4713 Harrison St. 6 Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 4 1899

7. AGE: Years 32 — Months 4 — Days 3 — If LESS than 1 day, ... hrs. or ..... min.

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) (STATE OR COUNTRY): Sweden

PARENTS
10. NAME OF FATHER: Ola Swenson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Sweden
12. MAIDEN NAME OF MOTHER: No record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): No Record.

14. INFORMANT (Address): Hjalmar Johnson 4713 Harrison

15. FILED 10/9, 1928 M. M. Crowe Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 7 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1928, to Oct 7th, 1928 that I last saw her alive on Oct 7, 1928, and that death occurred, on the date stated above, at 7 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Puerperal Sepsis
145A
108
Lobar (duration) 2 yrs. mos. 7 ds.
CONTRIBUTORY (SECONDARY) Pleuro Pneumonia
(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 4713 Harrison
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Usual Symptoms
(Signed) C E Cyrene, M. D
10/8, 1928 (Address) 3400 Kansas Blvd

*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: Forest Hill — DATE OF BURIAL: Oct 9 1928

20. UNDERTAKER: Mrs C L Forster — ADDRESS: KC Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

[illegible]
[illegible]
6734
3400 Karnes.