

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

Do not use this space.

43064

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City..... St. Louis Mo. (No. Lee & Shreve Avenues.) St. _____ Ward _____

File No. _____
 Registered No. 12351

2. FULL NAME Avanelle Dollie Johnson.

(a) Residence. No. 8616 Mora Lane St. 8 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 Female 4. COLOR OR RACE White. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/12/1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 11 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Buyer.
 (b) General nature of industry, business, or establishment in which employed (or employer) S.V. & Barney.
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mokane.
 (STATE OR COUNTRY) Missouri.

10. NAME OF FATHER Benjamin E. Johnson.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New Haven.
 (STATE OR COUNTRY) Missouri.

12. MAIDEN NAME OF MOTHER Maud A. Milton.

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

14. INFORMANT Ben E. Johnson
 (Address) 8616 Mora Lane

15. FILED 18 W. E. Standley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/15/28 19

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 _____ 8 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
210 lb Crushed B. Skull
Auto Collision in
210 City (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Cerebral
arteriosclerosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRIBUTED IF NOT AT PLACE OF DEATH

18. DID AN OPERATION PRECEDE DEATH? DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Thos. T. Dever M.D.
12/17/28 (Address) Coroner

*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 Claremont Okla DATE OF BURIAL Dec. 19, 1928
 20. UNDERTAKER Provoch and Co ADDRESS 3710 N. Grand Blvd.

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.

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

