

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

Do not use this space.

4783

1. PLACE OF DEATH

County Registration District No. 701
 Township St. Louis Primary Registration District No. 703 File No.
 City St. Louis (No. Mo. Baptiste Hospital) Registered No. 1474
 St. Ward)

2. FULL NAME

Leslie Homer Johnson
 (a) Residence No. 3016 Burlington St., 6 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Edna Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8, 1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
26 6 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Assembler
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer General Motors Corp

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

PARENTS
 10. NAME OF FATHER Robt Johnson
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Edna Read
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
 (STATE OR COUNTRY)

14. INFORMANT Edna Johnson
 (Address) 3016 Burlington

15. FILED JAN 30 1929
W. C. Wacker
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30, 1929

17. I HEREBY CERTIFY That I attended deceased from Jan 19, 1929, to Jan 30, 1929
 that I last saw h. alive on Jan 28, 1929, and that death occurred, on the date stated above, at 4:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

CONTRIBUTORY (SECONDARY) Bronchopneumonia
 (duration) yrs. mos. ds. 1
 (duration) yrs. mos. ds. 9

18. WHERE WAS DISEASE CONTRACTED Home 3016 Burlington
 IF NOT AT PLACE OF BIRTH

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

20. WHAT TEST CONFIRMED DIAGNOSIS? Physic's report
 (Signed) W. C. Wacker, M. D.
 , 19 (Address) 5368 Natural Bridge

*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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Paragard, Ark. DATE OF BURIAL Jan 30, 1929

22. UNDERTAKER Drehmann, Harold ADDRESS 1905 Union

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.

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1
2
2

W. C. Wacker

Handwritten scribbles or marks at the top center of the page.

Vertical mark or character on the left side of the top edge.

Vertical mark or character on the right side of the top edge.

Small vertical mark or character in the upper middle section.

Small mark or character in the lower middle section.