

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

Do not use this space.

4897

**1. PLACE OF DEATH**

County Saline  
Township.....  
City Marshall

Registration District No. 796  
Primary Registration District No. 3038

File No.....  
Registered No. 10  
St. .... Ward)

**2. FULL NAME**

Mary Katherine Johnson

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

F

**4. COLOR OR RACE**

Blk.

**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)**

June 6 1921

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
1	7	4	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Baby  
(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) Marshall Mo

**10. NAME OF FATHER**

Sam Johnson

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**12. MAIDEN NAME OF MOTHER**

Fannie Nichols

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

**14.**

INFORMANT Sam Johnson  
(Address) Marshall Mo

**15.**

FILED 1-15 1929 Mrs. John H. W. Lewis  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 1-10-1929

17. I HEREBY CERTIFY, That I attended deceased from 1-9-29, 1929, to 1-10-, 1929, that I last saw h. a. o. alive on 1-10-, 1929, and that death occurred, on the date stated above, at 4:11 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia  
108  
18h (duration) yrs. mos. 2 ds.

**CONTRIBUTORY (SECONDARY)** Conversive  
(duration) yrs. mos. 1 ds.

**18. WHERE WAS DISEASE CONTRACTED**

At home  
IF NOT AT PLACE OF DEATH.....

**19. DID AN OPERATION PRECEDE DEATH?** no DATE OF.....

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?** As above stated

(Signed) H. H. Webb, M. D.

, 19 (Address) Marshall, 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** **DATE OF BURIAL**

Fairview Cem Jan 12 1929  
**20. UNDERTAKER** marshall  
A. R. Vandiver Mo

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.

