

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

Do not use this space.

9104

MAR 27 1929

1. PLACE OF DEATH

County Saline Registration District No. 14479 File No. _____
 Township Cambridge Primary Registration District No. _____ Registered No. 15
 City Slater Mo (No. _____) St. _____ (Word)

2. FULL NAME

John Sterling Johnson
 (a) Residence No. _____ St. _____ 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 Male **4. COLOR OR RACE** White **5. Single, MARRIED, WIDOWED OR DIVORCED (write the word)** married

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF Frances Johnson
 (or) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 12 1854

7. AGE YEARS 76 MONTHS 10 DAYS 12 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (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) Carrollton Mo

10. NAME OF FATHER Columbus Johnson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) John Sterling Johnson Slater Mo R 204

15. FILED 52524 W. M. Tuttle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 29 1929

I HEREBY CERTIFY That I attended deceased from Jan 15 1929 to Feb 20 1929
 that I last saw him alive on Feb 8 1929, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
Suppurative Pneumonia
MIA (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) MIA (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED at home
 IF NOT AT PLACE OF DEATH: _____

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

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? St. Johnson
 (Signed) St. Lockwood, M. D.
 _____, 19 _____ (Address) Slater 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 Slater City Cemetery **DATE OF BURIAL** Feb 26 1929

20. UNDERTAKER Jones & Sager **ADDRESS** Slater Mo

M. 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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