JAN 25 1929 10121-1

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

Do not use this space.

10121-1

1. PLACE OF DEATH

County: Dekalb — Registration District No. 259

Township: Dallas — Primary Registration District No. 5367

City: ..... (No. ....., ... St. ..... Ward)

File No. .....

Registered No. .....

2. FULL NAME Lizzie 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Fem.	Wh	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 9th 1844

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	84	11	18	

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

235

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

24

PARENTS

10. NAME OF FATHER do not know

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

31

12. MAIDEN NAME OF MOTHER do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Do not know

31

14. INFORMANT August Johnson
(Address) Maysville Mo.

15. FILED May 10 1929 J. L. Phelps REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/26 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1929, to Mar 26, 1929 that I last saw her alive on Mar 26, 1929, and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial pneumonia
107 H
106 D

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Bronchitis

Don't know (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? 10000

(1) DID AN OPERATION PRECEDE DEATH? no. DATE OF .....

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) James F. Hedrick, M.D.

, 19 (Address) Westerly 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: Ridgeville Mo Cem. — DATE OF BURIAL: 3/28 19

20. UNDERTAKER: U. G. Pilcher — ADDRESS: Maysville.

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.