

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

Do not use this space.

12987

1. PLACE OF DEATH

County..... Registration District No. *791*
Township..... Primary Registration District No. *1008*
City *St. Louis, Mo.* (No. *5600*, *Arsenal*)

File No.....
Registered No. *3541*
St. *34th* Ward

2. FULL NAME

James Allen Johnson
(a) Residence No. *321 Antelope* St., *6* Ward.

(If nonresident give city or town and State)
Length of residence in city or town where death occurred *7* 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)

Male | *White* | *Single*

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

Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 8, 1926*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>2</i>	<i>5</i>	<i>13</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*
(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) *Tenn.*

10. NAME OF FATHER *Cletus Johnson*

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

12. MAIDEN NAME OF MOTHER *Gladys Johnson*

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

14. INFORMANT *Lorraine Kroner*
(Address) *5700 Arsenal St.*

15. FILED *10 22 1929* *W. C. Starker*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/21 1929*

17. I HEREBY CERTIFY, That I attended deceased from *3/15*, 19 *29*, to *3/21*, 19 *29*, that I last saw him alive on *3/21*, 19 *29*, and that death occurred, on the date stated above, at *2:15 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Laryngitis, Acute
10.5 Bronchopneumonia (duration) yrs. mos. *22* ds.
Secondary (SECONDARY) (duration) yrs. mos. *6* ds.

18. WHERE WAS DISEASE CONTRACTED *321 Antelope*
IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *3/21*
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS? *Physical + Culture.*
(Signed) *Dr. J. H. H. H.*, M. D.

*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 *Sharon, Tenn.* DATE OF BURIAL *3/23 1929*

20. UNDERTAKER *W. A. Stock* ADDRESS *207 E. Grand*

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

NOTE.—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.

MARGIN RESERVED FOR BINDING

2
2
2

