

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

Do not use this space.

18423
2170

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. _____ Registered No. _____
 City La Mo General Hospital 10022 St. _____ Ward _____

2. FULL NAME

Addie Johnson
 (a) Residence. No. 2437 Highland St., 4 Ward. _____ (If nonresident, give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23, 1892

7. AGE YEARS MONTHS DYS If LESS than 1 day, hrs. or min.
37 5 10

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Lexington, Kentucky
 (STATE OR COUNTRY)

10. NAME OF FATHER Porter Nelson

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

12. MAIDEN NAME OF MOTHER Mattie Fields

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

14. INFORMANT Patience Nesell
 (Address) 2437 Highland

15. FILED 5/31, 1929 M. M. Crowe
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 5 25, 1929 to 5-30, 1929 that I last saw him alive on 5-30, 1929 and that death occurred, on the date stated above, at 3:15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23 H
69 B
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Splenic
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH Home

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

WHAT TEST CONFIRMED DIAGNOSIS clinical laboratory
 (Signed) H. M. Smith M. D.

5/30, 1929 (Address) General Hospital

*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 Highland
 DATE OF BURIAL 6-3 1929

20. UNDERTAKER K. C. Emb. Cas. Co
 ADDRESS 440 State

WHITE 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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