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

Do not use this space.

20272

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 5955

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Sarah Johnson

(a) Residence. No. 216 Johnson St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 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: Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22 1894

7. AGE: Years 34 | Months 8 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

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) St. Louis
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Jim Blue
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Mary Raven
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED MAY 31 1929 Mark Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-18- 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-15- 1929, to 5-18- 1929 that I last saw her alive on 5-18- 1929 and that death occurred, on the date stated above, at 10 m. 10 P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. myocarditis
93C
118C (duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Acute Gastritis
Cause unknown (duration) ..... yrs. ..... mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) T. E. Cunningham, M. D
, 19 (Address) 2945 Sawton

*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: Father Dixon's Cemetary
DATE OF BURIAL: May 31 199

20. UNDERTAKER: Metropolitan Funeral Home
ADDRESS: 3229 Lucas

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

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.