

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

Do not use this space.

31429

1. PLACE OF DEATH

County New Madrid Registration District No. 55
 Township Anderson Primary Registration District No. HO 33
 City Esidon (No. _____) St. _____ Ward _____

File No. 8
 Registered No. 820

2. FULL NAME

Mary Elizabeth Johnson
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 20-1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>1</u>	<u>0</u>	<u>24</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Esidon
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Joseph Johnson

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

12. MAIDEN NAME OF MOTHER Laura Keen

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

14. INFORMANT J. B. Johnson
 (Address) Esidon Mo

15. FILE NO. Ed 10 29 1929 M.V. Messner
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13th 19 29

17. I HEREBY CERTIFY, That I attended deceased from Sept 8th 19 29 to Sept 13th 19 29
 that I last saw her alive on Sept 12th 19 29, and that death occurred, on the date stated above, at 7:00 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ducto-enteritis
1190
 (duration) _____ yrs. _____ mos. 14 ds.
 CONTRIBUTORY 11313
 (SECONDARY) (duration) _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

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

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) William, M. D.
9-13, 1929 (Address) Clarkton 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 Standfield Cemetery DATE OF BURIAL Sept 13 19 29

20. UNDERTAKER H. Meentemeyer ADDRESS Esidon Mo

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.

WRITE PLAINLY, WITH CAPITALS

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