

WRITE 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.

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

Do not use this space.

33044

1. PLACE OF DEATH
County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St Joseph (No. _____) State Hospital #2 St. _____ Ward _____

File No. _____
Registered No. 1202
St. _____ Ward _____

2. FULL NAME Lindsay Johnson
(a) Residence. No. State Hosp # 2 St. 1001 B Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 10 mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 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 _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1929
17. I HEREBY CERTIFY, That I attended deceased from april 1, 1929, to Oct 14, 1929 that I last saw him/her alive on Oct 14, 1929, and that death occurred, on the date stated above, at 11:30 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1858
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 71 + Unknown

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Intestines + Peritonium

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salvage
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: _____

9. BIRTHPLACE (CITY OR TOWN) Do not know
(STATE OR COUNTRY) Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) D. G. Johnson, M. D.
10-14, 1929 (Address) State Hosp # 2 St Joseph

14. INFORMANT State Hosp # 2
(Address) St Joseph

*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.

15. FILED 10/21, 1929 John G. Webb REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL State Hospital Cemetery DATE OF BURIAL Oct 27, 1929
20. UNDERTAKER Walter Meichoffer ADDRESS 1302 Faraon St.

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