

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

Do not use this space.

35715

1. PLACE OF DEATH

County.....
Township.....
City..... (No. *City Hosp. #2*)

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **10508**
St. Ward)

2. FULL NAME

Georgia Johnson
(a) Residence, No. *3019 Main St.* St., **3** Ward.
(Usual place of abode) *MAURICE* (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *28* 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) *widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1-30-1871*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
58 9 23

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

9. BIRTHPLACE (CITY OR TOWN) *Missouri*
(STATE OR COUNTRY)

10. NAME OF FATHER *Andrew Lewis*

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

12. MAIDEN NAME OF MOTHER *Ariana Nelson*

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

14. INFORMANT *W. Glendon Creath*
(Address) *City Hospital #2*

15. FILED *26 1929* *W. C. Stankley*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10-23 19 29*

17. I HEREBY CERTIFY, That I attended deceased from *9-20* 1929, to *10-23* 1929, and that I last saw her alive on *10-22* 1929, and that death occurred, on the date stated above, at *3 30 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
uterine carcinoma
48
10
HA (duration) *2* yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *Cancer of breast*
(duration) *24* yrs. mos. ds.

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

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

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Biopsy*
(Signed) *Hazel Catlett*, M. D.
10/23 1929 (Address) *City Hosp #2*

*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 *Greenwood Cemetery* DATE OF BURIAL *10/27 1929*

20. UNDERTAKER *C. W. Roberts* ADDRESS *3035 Leavenworth*

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.

23
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2

