

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

Do not use this space:

36489

1. PLACE OF DEATH

County Butler
 Township St. Francis
 City

Registration District No. 990
 Primary Registration District No. 2133

File No.
 Registered No. 8
 St. Ward)

2. FULL NAME

Oydo Johnson

(a) Residence. No. St. Francis Township St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7 Nov. 1929

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

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on....., 19....., and the death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Don't know found Dead in Bed 2003

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 2 - 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

CONTRIBUTORY (SECONDARY) 205

9. BIRTHPLACE (CITY OR TOWN; (STATE OR COUNTRY)

Butler Co. Mo

10. NAME OF FATHER

John Johnson

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

Butler Co. Mo

12. MAIDEN NAME OF MOTHER

Midley

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

Missouri

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. H. H. Carter, M.D.

, 19 (Address) Residence 710

*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.

14. INFORMANT John Johnson
 (Address) Wappahilla Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Rita Bruch

Nov 7 1929

15. FILED Nov 7, 1929

20. UNDERTAKER

ADDRESS

W. J. Zell

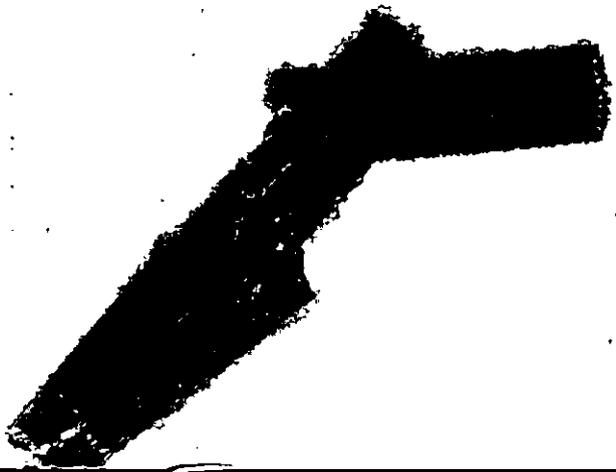
REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation of deceased.

22
 28 NW

1
 2
 1

B.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Butler Registration District No. 990 File No. _____
 Township St. Francis Primary Registration District No. 3-133 Registered No. 8
 City _____ (No. _____ St. _____ Ward)

2. FULL NAME

Orlando Johnson

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

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (circle the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 7 1929

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 _____ (duration) _____ yrs. _____ mos. _____ ds.

8. OCCUPATION OF DECEASED

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

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

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS? _____

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

(Signed) _____, M. D.
 _____, 19____ (Address)

*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.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 11-7-29 Alvella REGISTRAR

20. UNDERTAKER ADDRESS
Frank Jones Rombauer St.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

REGISTRATION STATEMENT OF OCCUPATION IS VALID FOR 1 YEAR

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