

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

Do not use this space.

36516

File No. _____
Registered No. 244
St. _____ Ward _____

1. PLACE OF DEATH
County Caloway Registration District No. 104
Township _____ Primary Registration District No. 3008
City Fulton (No. _____) St. _____ Ward _____

2. FULL NAME Henry Johnson
(a) Residence. No. _____ St. _____ Ward Linsley Co Mo
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 22 yrs. 7 mos. 7 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 Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) DK

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>About 70</u>				

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

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

10. NAME OF FATHER DK

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

12. MAIDEN NAME OF MOTHER DK

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

14. INFORMANT Hospital member
(Address) _____

15. Dec 29 1929 R. N. Crews
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 1929

17. I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to Nov 30, 1929, that I last saw him alive on Nov 30, 1929, and that death occurred, on the date stated above, at 7:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Public Cancer Carcinoma
SIC
53E

(duration) 4 yrs. _____ mos. _____ ds.

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

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) D. Adams, M. D.
, 19 _____ (Address) Fulton 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 Luxville Mo DATE OF BURIAL Dec 3rd 1929
BY UNDERTAKER Oli Bell ADDRESS Fulton, Mo

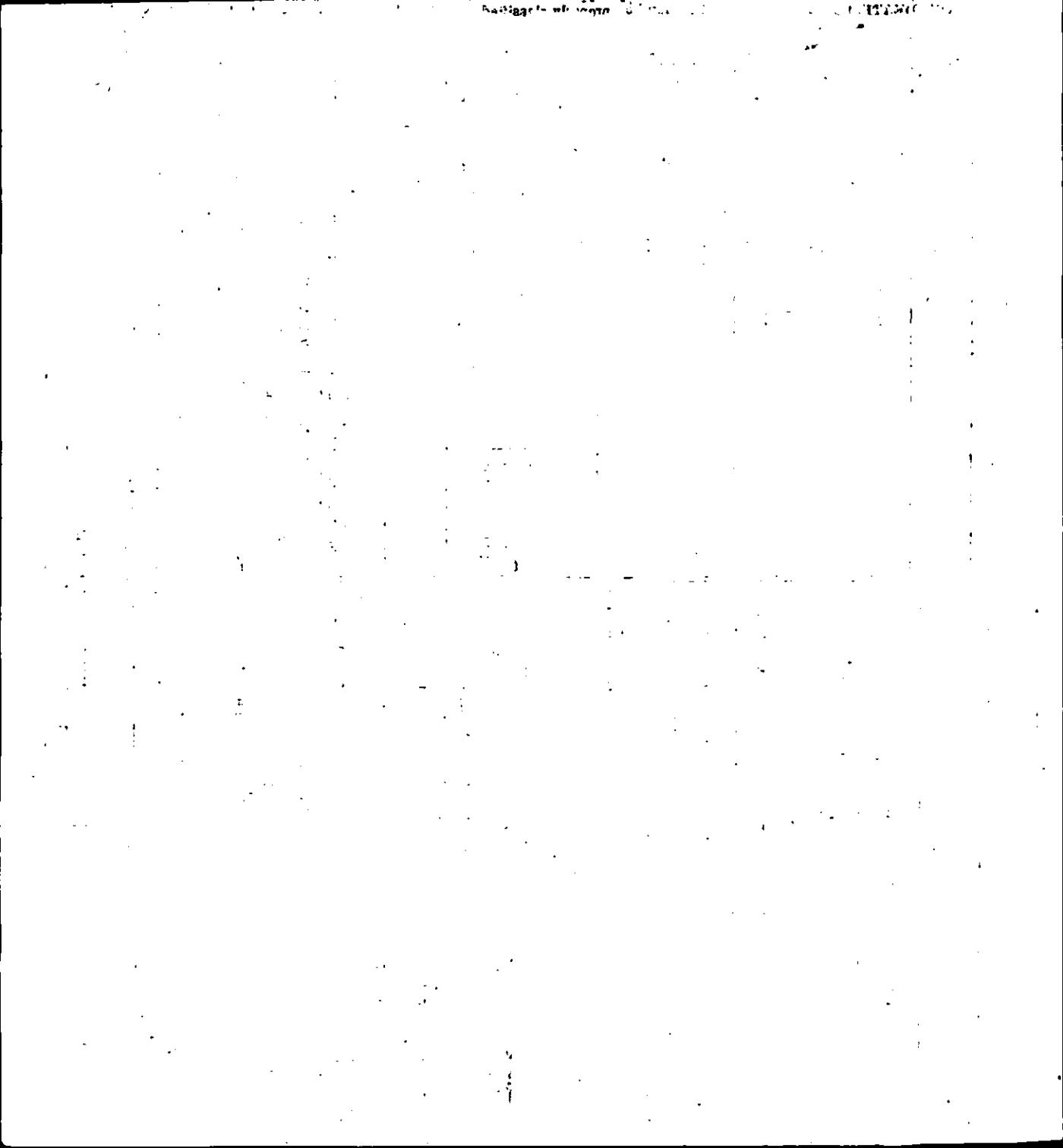
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

14
81929

27

31

PARENTS



**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 Callaway
Township.....
City Fulton (No.)

Registration District No. 104
Primary Registration District No. 3008

File No.
Registered No. 244
St. Ward)

2. FULL NAME

Henry 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 B. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Sl.

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 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..... m.

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.

Pelvic Cancer
Gonorrhea
Cancer of Prostate
(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

10. NAME OF FATHER

IF NOT AT PLACE OF DEATH.....

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

DID AN OPERATION PRECEDE DEATH? DATE OF.....

12. MAIDEN NAME OF MOTHER

WAS THERE AN AUTOPSY?

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

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

14. INFORMANT..... (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.

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

15. Nov 30 1929 R. M. Cream REGISTRAR

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-36516

UNITED STATES
DEPARTMENT OF
AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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