

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

Do not use this space.

39753

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St. Joseph (No. Noves-Baptist Hospital)

File No. _____
Registered No. 1433
St. _____ Ward _____

2. FULL NAME Lillie Elizabeth Johnson,

(a) Residence. No. 215 West Elk St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 14 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 22, 1883

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	46	5	24	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Paris,
(STATE OR COUNTRY) Texas,

PARENTS	10. NAME OF FATHER <u>Unknown,</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown,</u> (STATE OR COUNTRY) <u>Unknown,</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown,</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown,</u> (STATE OR COUNTRY) <u>Unknown,</u>

14. INFORMANT Joseph H. Johnson
(Address) 215 West Elk Street.

15. FILED DEC 17 1929 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 24, 1929, to Dec 16, 1929 that I last saw him alive on Dec 16, 1929, and that death occurred, on the date stated above, at 12:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis (General)

127
129 (duration) yrs. mos. 14 ds.
CONTRIBUTORY Infected gall bladder
(SECONDARY) (duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 11-28-29

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. W. Kearby, M. D.
12/17, 1929 (Address) St Joseph 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 St Mary Cem DATE OF BURIAL Dec. 16, 1929

20. UNDERTAKER Heaton & [Signature] ADDRESS 319 S. 10 St.

Funeral Home

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.

Handwritten notes and signatures in the top left margin.

**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 Duchman Registration District No. 85 File No. _____
 Township St Joseph Primary Registration District No. 1001 Registered No. 1433
 City St Joseph (No. _____) St. _____ Ward _____

2. FULL NAME Lillie Elizabeth 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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 _____

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

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) _____

15. FILED 2/3 1930 John G. Giff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 19 29

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

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

CONTRIBUTORY (SECONDARY) Infected Gall bladder
(Invasion by bacteria) (duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH: _____
 WAS THERE AN AUTOPSY? 124a
 WHAT TEST CONFIRMED DIAGNOSIS: _____
 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

N. B. Every item of information should be fully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-39753