

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

Do not use this space.

1104

**1. PLACE OF DEATH**

County Jackson  
Township Haus  
City Haus City

Registration District No. 399

Primary Registration District No. 3533 Highland

File No. \_\_\_\_\_  
Registered No. 90  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Augusta Johnson  
(a) Residence. No. 3533 Highland, 13 Ward.

(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**

3. SEX Fe. 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 John F. Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 18 - 1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1
				day, _____ hrs. or _____ min.
	52	4	20	

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

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

10. NAME OF FATHER Mrs Hansen

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT John F. Johnson  
(Address) 3533 Highland

15. Jan 8 1930 M. M. Crowe  
REGISTRAR ans

**MEDICAL CERTIFICATE OF DEATH**

Wednes

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 8, 1930 that I last saw him alive on Jan 8, 1930, and that death occurred, on the date stated above, at 7:45 am m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Obstruction of bowels  
Voluntus

CONTRIBUTORY (SECONDARY) Peritonitis (duration) yrs. mos. ds. 3

18. WHERE WAS DISEASE CONTRACTED 118 B1

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) W. F. Hagedorn, M. D.

Jan 6, 1930 (Address) 900 North Blvd

\*State the DISEASES 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 Edenwood Cemetery DATE OF BURIAL 1-10 1930

20. UNDERTAKER Clyde Funeral Home ADDRESS 1000 Lindenwood

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.

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