

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

Do not use this space.

10250

1. PLACE OF DEATH

County..... Registration District No. 791
Township St. Louis Primary Registration District No. 1003
City St. Louis (No. 5600 Arsenal St. 24th Ward)

File No.....
Registered No. 2213
St. 24th Ward

2. FULL NAME Truman Johnson

(a) Residence. No. 3969^{1/2} Maffit St. 11 Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-5-1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
8 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. nil
(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 James Johnson

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

12. MAIDEN NAME OF MOTHER Marie Thompson

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

14. INFORMANT E. Sheridan
(Address) ISOLATION HOSPITAL

15. FILED 19 1930 W. C. Starker REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-2 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-2, 1930, to 3-2, 1930 that I last saw h. un alive on 3-2, 1930, and that death occurred, on the date stated above, at 4:28 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

109 B
39 A
Atitis media
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Pneumo pneumonia
Secondary (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED 100 W

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Belknap M. D.
3-3-30 ISOLATION HOSPITAL

*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

Calvary Mar 4 1930

20. UNDERTAKER Paromachig ADDRESS 4740 N. Florissant

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.

