

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *7 791*
Primary Registration District No. *1003*
(No. *4308 Cottage*)

File No. *14495*
Registered No. *3749*
St. Ward)

2. FULL NAME

Lewis Johnson
(a) Residence. No. *4308 Cottage* St. *11* 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 <i>Male</i>	4. COLOR OR RACE <i>Negro</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Temple Johnson</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>April 1845</i>		
7. AGE YEARS <i>abt 85</i>	MONTHS <i>unknown</i>	DAYS <i>unknown</i>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>Red job</i> (c) Name of employer		

PARENTS	9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Missouri</i>
	10. NAME OF FATHER <i>unknown</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>" "</i>
	12. MAIDEN NAME OF MOTHER <i>Matilda Cole</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>

14. INFORMANT (Address) <i>Temple Johnson 4308 Cottage</i>
15. FILED <i>APR 25 1930</i> REGISTRAR <i>W. C. Taylor</i>

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-12-1930*
17. I HEREBY CERTIFY, That I attended deceased from *10:30* to *11:40* 19*30* that I last saw him alive on *3/7/30* at *11:30* and that death occurred, on the date stated above, at *7:30* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronical interstitial nephritis
131 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *1290* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *H. L. Perry*, M. D.
4-14-30 (Address) *4452 Kennedy*

*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
Father Wilson Cem. *4-15-1930*
20. UNDERTAKER ADDRESS
State's Funeral Home *4107 Linn*

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.

