Dr C H Leslie
Kirk Trust Bldg

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

Do not use this space. 20978

[redacted]

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 5796

City St Louis (No. St Lukes Hospital St. ..... Ward)

2. FULL NAME Herrick, Johnson Jr.

(a) Residence. No. Kirkwood Mo St., 12 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): Aug. 24-1927

7. AGE: YEARS 2 MONTHS 9 DAYS 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(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): Missouri

PARENTS
10. NAME OF FATHER: Herrick, Johnson Jr.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Florida
12. MAIDEN NAME OF MOTHER: Julia Agnes Sullivan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mass.

14. INFORMANT: Herrick, Johnson
(Address) 235 Midway Ave Kirkwood Mo

15. FILED JUN 16 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 14 1930

17. I HEREBY CERTIFY, That I attended deceased from 6/10, 1930, to 6/14, 1930, that I last saw him alive on 6/14, 1930, and that death occurred, on the date stated above, at 11.15 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemolytic Streptococcic Septicemia
154
3/2 (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY): Osteomyelitis R. Tibia + R. ulcerh (duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: Kirkwood, Mo
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? Partial on bones
WHAT TEST CONFIRMED DIAGNOSIS? Blood culture
(Signed) C H Leslie M. D.
6/16 1930 (Address) Kirkwood, 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 Peters Cemetery — DATE OF BURIAL: June 17 1930

20. UNDERTAKER: Louis H Bopp — ADDRESS: Kirkwood Mo

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.