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

Do not use this space.

22380

1. PLACE OF DEATH
County: Dallas
Township: Sheridan
City: Fair Grove (No. ..... St. ..... Ward)

Registration District No. 243
Primary Registration District No. 5337

File No. .....
Registered No. .....

2. FULL NAME: Ralph 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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec-1-1908

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22	7	10	

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

9. BIRTHPLACE (CITY OR TOWN): Dallas Co
(STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: H. J. Johnson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Johnson
(STATE OR COUNTRY): Co Mo.
12. MAIDEN NAME OF MOTHER: Mary Decker
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Dallas
(STATE OR COUNTRY): Co Mo

14. INFORMANT: Mary Johnson
(Address): Fair Grove Mo

15. FILED: 8/10 1930 M. V. Rea
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July-11-1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Multiple Sclerosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(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) Claude O. Hammer, M. D
7-12, 1930 (Address) Buffalo 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: Mallard Cemetery — DATE OF BURIAL: July 12 1930

20. UNDERTAKER: L. B. Jones — ADDRESS: Buffalo Mo

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.

THIS IS A PERMANENT RECORD