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

Do not use this space.

23194

1. PLACE OF DEATH
County: Jackson
Township: Kan
City: K.C. Mo (No. General Hospital #2 St. Ward)
Registration District No. 399
Primary Registration District No. 1002
File No. 3442
Registered No.

2. FULL NAME: Annie Johnson
(a) Residence. No. 26 Lydia St., 1 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: F
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 12/10/1876

7. AGE: Years 54 | Months 6 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laundress
(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): Springfield Mo.

PARENTS
10. NAME OF FATHER: Fred Wilson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): UN
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Record Clerk
(Address): General Hosp. #2

15. FILED 8/19, 1930 M. M. Crane
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-8 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-3, 1930, to 7-8, 1930, that I last saw h. alive on 7-8, 1930, and that death occurred, on the date stated above, at 6:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia
Chronic Interstitial Nephritis
151
152 Unknown (duration) ....yrs....mos....ds.

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

18. WHERE WAS DISEASE CONTRACTED: 1294
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. M. Smith, M. D.
7/10, 1930 (Address) Gen. Hosp. #2

*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: K.C. Western Dental School | DATE OF BURIAL: 7-14 1930
20. UNDERTAKER: Mo State Anatomical Board | ADDRESS: Jefferson City

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.