

SEP 24 1930

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

Do not use this space.

26385

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 2004
City Springfield (No. Baptist Hospital) St. Ward

File No.
Registered No. 589 St. Ward

2. FULL NAME

Sarah Louise Johnson

(a) Residence. No. Warrensburg, Mo. St. 3 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-2-1904

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 10 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(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

10. NAME OF FATHER

Frank Foster

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) South Cal.

12. MAIDEN NAME OF MOTHER

Kathie French

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

14.

INFORMANT Bertha Haacker
(Address) Billings, Mo.

15.

FILED 8/2 30 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from July 24 1930 to Aug 1 1930 that I last saw her alive on Aug 1 1930 and that death occurred, on the date stated above at 5:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Genl Peritonitis

CONTRIBUTORY (SECONDARY) acute gangrenous appendicitis with shock due to white abortion
2-3 mos. (duration) yrs. mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED

1400 Billings

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF July 24 30

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) William Green, M. D.

82 1930 (Address) Springfield, 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

W. O. Davis Cemetery

DATE OF BURIAL

8-4 1930

20. UNDERTAKER

W. S. Wallace

ADDRESS

Billings, 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.

