

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

Do not use this space.

32996

4226

1. PLACE OF DEATH

County Person Registration District No. 390
 Township West Primary Registration District No. 3002
 City West City (No. General Hosp #2) St. _____ Ward)

2. FULL NAME

Leila Johnson
 (a) Residence. No. 1527 Grace St. 2 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 Female 4. COLOR OR RACE Color 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) Unknown 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
? 65 Unknown

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home.
 (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) Arkansas.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address) Reed Clark City Hoop # 2

15. FILED 10-18-30 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 10/13 1930 to 10/14 1930 that I last saw h. alive on 10/14 1930 and that death occurred, on the date stated above, at 6:40 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Cordiac to thum
95%
132 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chr. hepatitis
Artemia (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
 IF NOT AT PLACE OF DEATH

DATE OF OPERATION PRECEDE DEATH _____ DATE OF _____

19. WHAT TEST CONFIRMED DIAGNOSIS St. Gallenic
 (Signed) D. M. Miller M. D.

10 15, 1930 (Address) City Hoop # 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 Restlawn Cem. DATE OF BURIAL 10/18 1930

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Hyde

LY, 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.

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