

OCT 30 1930

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

Do not use this space.

33613

1. PLACE OF DEATH

County Morgan
Township Osage
City Glattstein Mo

Registration District No. 397
Primary Registration District No. 3793

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Eloy Johnson
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. 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) Jan 30 1913

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
17 | 8 | 6

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) Morgan Co Mo

10. NAME OF FATHER Fred Johnson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Morgan Co Mo

12. MAIDEN NAME OF MOTHER Emma Prime

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Morgan Co Mo

14. INFORMANT (Address) Fred Johnson
Glattstein Mo

15. FILED _____, 19____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 9th 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 10th 1930 to Oct 4th 1930
that I last saw h. a. x. alive on Oct 4th 1930, and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
typhoid fever

CONTRIBUTORY (SECONDARY) 10 (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

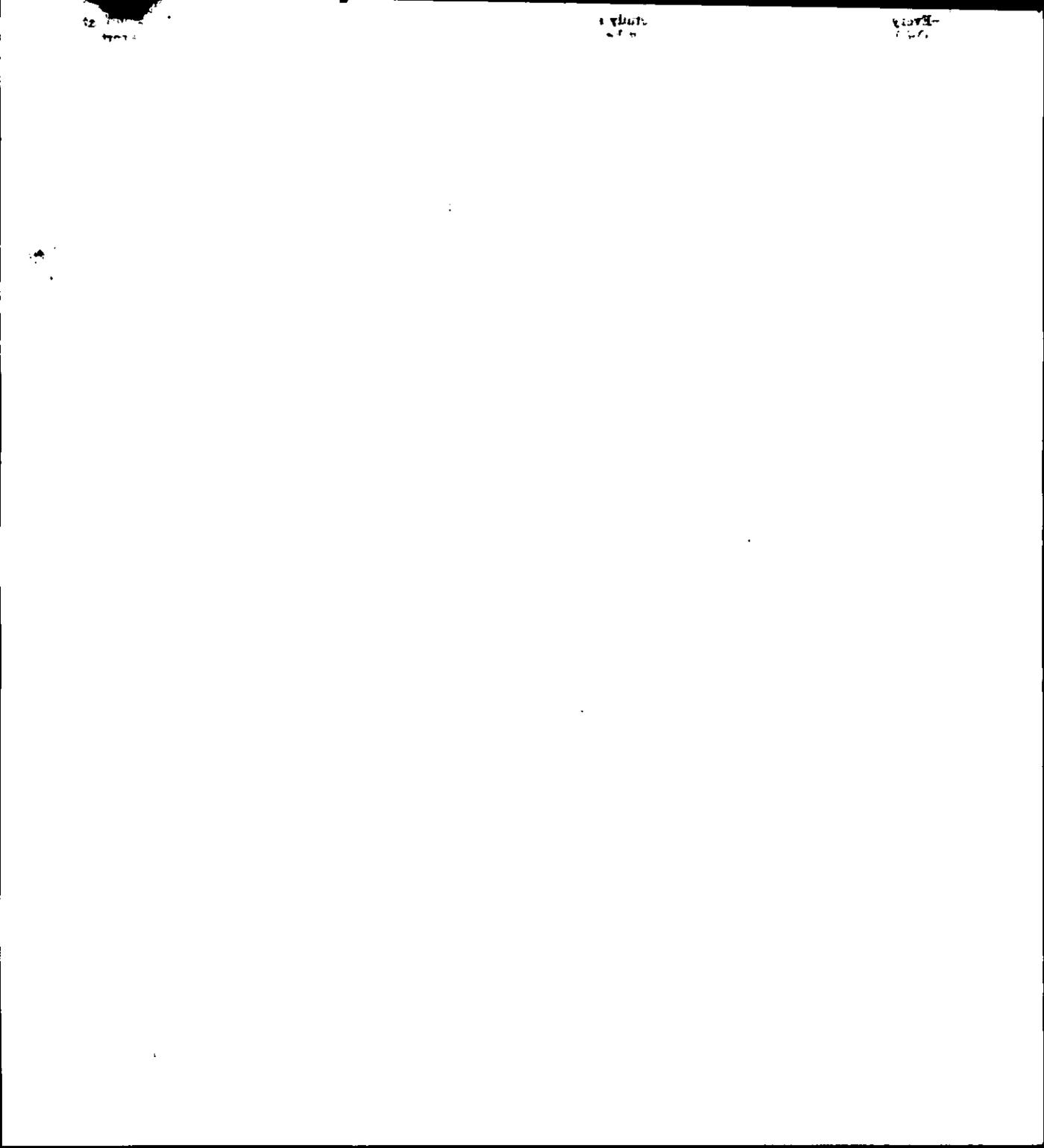
WHAT TEST CONFIRMED DIAGNOSIS? symptoms
(Signed) Wm. Bell, M. D.
Oct 4, 1930 (Address) versailles Mo

*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 Reslie Cemetery DATE OF BURIAL Oct 6th 1930

20. UNDERTAKER Wm. Bell ADDRESS _____

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.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Morgan
Township Osage
City (No.) St. Ward

Registration District No. 597
Primary Registration District No. 5792

File No. 597
Registered No. 5792
St. Ward

2. FULL NAME

Erroy 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (or for the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 - 1913

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
17 8 4

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) Morgan Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Fred Johnson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Morgan Co Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Grada Prime

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Morgan Co Mo
(STATE OR COUNTRY)

14. INFORMANT Fred Johnson
(Address) Gladstone Mo

15. FILED 12/9 30 W L Hetherington
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 4 1930

17. I HEREBY CERTIFY That I attended deceased from Sept 18 1930 to Oct 4 1930
that I last saw him alive on Oct 4 1930, and that death occurred, on the date stated above at 7 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

typhoid fever
(duration) yrs. mos. ds. 24

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) Wm Webb, M. D.
Oct 4 1930 (Address) Versailles 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 Witchie Cemetery DATE OF BURIAL Oct 6 1930

20. UNDERTAKER Kidwells ADDRESS Versailles Mo

SUPPLEMENTARY

N. B. - 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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