

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

Do not use this space.

34808

File No. _____
Registered No. **10200**

1. PLACE OF DEATH

County _____ Registration District No. **101**
Township _____ Primary Registration District No. **101A**
City **St. Louis** (No. **3408^a**) **Pine** St. _____ Ward _____

2. FULL NAME

Albert H. Johnson
(a) Residence. No. **3405^a Pine** St. **M** 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 <i>Male</i>	4. COLOR OR RACE <i>Col.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widowed</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>Abt.</i>	<i>90</i>	<i>-</i>	<i>-</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Soldier (Retired)*
(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) *Cleveland Ohio*

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) *Mrs. Lucy Wesley 3405^a Pine St.*

15. FILED *1933 May 6* *Starkoff* REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10 - 22 19 30*

17. I HEREBY CERTIFY, That I attended deceased from *10-21*
_____, 19 *30* to *10-22*, 19 *30*
(that I last saw h. _____ alive on *10-22*, 19 *30* and that death occurred, on the date stated above, at *10* _____ m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
90% *Adipity* (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) *90%* (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED *90%*
IF NOT AT PLACE OF DEATH _____

8 **DID AN OPERATION PRECEDE DEATH?** _____ DATE OF _____
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *W.R. Williams*, M. D.
, 19 (Address) *823 N. 164*

*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 *Greenwood Cem* **DATE OF BURIAL** *10/27 19 30*

20. UNDERTAKER *C. W. Roberts* **ADDRESS** *3035 Duane*

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.

