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

Do not use this space.

37797

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 10903

Township ..... Primary Registration District No. ..... Registered No. 10903

City ..... (No. 3113a Lawton St. ..... Ward)

2. FULL NAME Mattie Johnson

(a) Residence. No. 3113a Lawton St. 21 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fenal	Col	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27, 1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	52	2	20	

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) Springfield Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Samuel Rice
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Hannah Louise
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT Pauline Barker
(Address) 108 S Jefferson

15. NOV 18 1930 FILED ..... 19 Max [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11 - 16 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Nov 16, 1930, that I last saw her alive on Nov 16, 1930, and that death occurred, on the date stated above, at 10 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis

(duration) ..... yrs. 1 mos. 10 ds.

CONTRIBUTORY (SECONDARY) General Wasting & fatigue

(duration) ..... yrs. ..... mos. 3 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? Clinical & X Ray

(Signed) [illegible], M. D.
, 19 (Address) [illegible]

*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	DATE OF BURIAL
Springfield Mo	11-19, 1930
20. UNDERTAKER	ADDRESS
American Funeral Home	Pine 3444

N. B.—Every item of information should be carefully supplied. AGE should be [illegible]. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.