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

Do not use this space.

5571

1. PLACE OF DEATH

County Jackson — Registration District No. 39 — File No. 661

Township Kan — Primary Registration District No. — Registered No.

City K. C. Mo. (No. 3915 Campbell St. St. Ward)

2. FULL NAME Nellie Gertrude Johnson

(a) Residence. No. 3915 Campbell St., 6 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)
Fe	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-6-1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	67	5	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 233
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Peter Gallager
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) New York
12. MAIDEN NAME OF MOTHER No Record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record 31

14. INFORMANT W. A. Johnson
(Address) 3915 Campbell St.

15. FILED 2/11, 1931 M. M. Crowe REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-10, 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1931, to Feb 10, 1931, that I last saw her alive on Feb 10, 1931, and that death occurred, on the date stated above, at 8:45 Am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
8 Yr
10 Yr (duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (SECONDARY) Hypertention
Unknown (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? Clinical

(Signed) Fred J. Hatch, M. D.
2/11, 1931 (Address) 1010 Chambers Bldg

*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
Calvary	2-12-1931

20. UNDERTAKER	ADDRESS
Mrs. C. L. Foster	K.C. 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.