

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

Do not use this space.

1. PLACE OF DEATH

County Ruehman

Registration District No. 85

Township St Joseph Mo

Primary Registration District No. 1001

City St Joseph Mo

State Hospital #2

File No. 13230

Registered No. 396

St.

Ward

2. FULL NAME Robert Johnson

(a) Residence No. State Hospital, #2

St.

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

M

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

Unknown

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

Unknown 1865

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, .....hrs. or .....min.

64

Unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Unknown

(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)

Unknown

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)

State Hospital Records  
St Joseph Mo

15.

FILED APR 16 1931

John R Bender

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 5 1931

17. I HEREBY CERTIFY, That I attended deceased from Mich 22 1931 to April 5 1931 that I last saw him alive on Apr 5 1931 and that death occurred, on the date stated above, at 6:45 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage  
9.191

CONTRIBUTORY (SECONDARY)

age 82

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

(Signed) R. M. Miles M. D.

Apr 5 1931 (Address) St Joseph 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

DATE OF BURIAL

State Hospital Cem

4-16-31

20. UNDERTAKER

Graves Funeral Home 806 S 17

B.F.

WRITE PLAINLY, 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.

MAY 2 1 1931

