

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

Do not use this space.

16086

1. PLACE OF DEATH

County..... Registration District No. **701**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo** (No. **4341 West Belle**)

File No.....
Registered No. **4562**
St. Ward)

2. FULL NAME

William Johnson
(a) Residence. No. **4341 West Belle Pl.** St., **11** 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 Negro	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Roxy Johnson				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 7-1882				
7. AGE YEARS 48	MONTHS 8	DAYS 5	IF LESS than 1 day, hrs. or min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Janitor 3rd (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo**
(STATE OR COUNTRY)

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

14. INFORMANT **Roxy Johnson**
(Address) **4341 West Belle Pl.**

15. FILED **9/19/31** REGISTRAR **W. C. Starnett**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4/12 1931**

17. I HEREBY CERTIFY, That I attended deceased from **4/11 1931** to **4/12 1931** that I last saw him alive on **4/12/1931** at **4:00** p.m., and that death occurred, on the date stated above, at **4:00** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
1.5/10/31 (duration) yrs. **4** mos. ds.

CONTRIBUTORY (SECONDARY) **1.5/10/31** (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Chas. E. Hunt** M. D.
4/14 1931 (Address) **4322A East**

*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
Calvary DATE OF BURIAL **Apr 16th 1931**

20. UNDERTAKER
Gate Funeral Home ADDRESS **4107 Finney**

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.

Chas E Herriot