

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

Do not use this space.

**1. PLACE OF DEATH**

County Wheeler  
Township Goodshure  
City Wheeler (No. 110)

Registration District No. 383  
Primary Registration District No. 5034

File No. 21277  
Registered No. 121  
St. \_\_\_\_\_ Ward)

**2. FULL NAME**

James A. Johnson  
(a) Residence No. 11 St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
75 9 14

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farmer  
(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) Deming Co. Iowa

10. NAME OF FATHER Wm. B. Johnson  
11. BIRTHPLACE OF FATHER (CITY OR TOWN), (STATE OR COUNTRY) Scott Co. Mo.  
12. MAIDEN NAME OF MOTHER Anna Judd  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN), (STATE OR COUNTRY) Iowa

14. INFORMANT (Address) James B. Johnson  
Albia, Iowa

15. FILED 7-3-31 Genevieve L. Johnson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1931

17. I HEREBY CERTIFY, That I attended deceased from June 19 1931 to June 19 1931, 1931, that I last saw him alive on June 19 1931, and that death occurred, on the date stated above, at 3:20 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

acute indigestion  
causing angina pectoris  
94 W  
11.8 C (duration) 10 hrs. 4 mos. 4 ds.  
10a senility  
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Physical  
(Signed) C.R. Terrell, M. D.  
, 19 (Address) Mtn. View 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 Mtn View Mo. DATE OF BURIAL June 21 1931

20. UNDERTAKER J. J. Mean ADDRESS Mtn View 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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

44-5-1001

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statement

about

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Bowling Registration District No. 983  
Township Goldsbury Primary Registration District No. 5-5-34  
City ..... (No. .....) St. ..... Ward .....

File No. .....

Registered No. 12

**2. FULL NAME**

James A. Johnson  
(a) Residence, No. ..... St. ..... 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9 1931

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

22. I HEREBY CERTIFY, That I attended deceased from ..... to ....., 19.....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-5-1845

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.

7. AGE YEARS 75 MONTHS 9 DAYS 14 If LESS than 1 day, ..... hrs. or ..... min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) .....  
11. Total time (years) spent in this occupation .....

Date of onset .....

Other contributory causes of importance: .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation ..... Date of .....

13. NAME

What test confirmed diagnosis? ..... Was there an autopsy? .....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:

15. MAIDEN NAME

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? ..... (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE ..... DATE ....., 19.....

Manner of injury .....

Nature of injury .....

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

20. FILED 7-3 19 31 Genevieve F. Rose Registrar (Address) .....

**SUPPLEMENTARY**

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

RECORD

5-21277