

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

Do not use this space.

23315

**1. PLACE OF DEATH**

County .....

Registration District No. **791**

Township .....

Primary Registration District No. **1003**

City *St. Louis, Mo* (No. *3576* block *18*)

File No. ....

Registered No. **6780**

St. .... Ward)

**2. FULL NAME** *Lozie Johnston*

(a) Residence. No. *3576* block *18* 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**

3. SEX *Female* 4. COLOR OR RACE *Caucasian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *abt 52 - -*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Housekeeper*  
(b) General nature of industry, business, or establishment in which employed (or employer) *341*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Crosson*  
(STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *James Holman*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Crosson*  
(STATE OR COUNTRY) *Missouri*

12. MAIDEN NAME OF MOTHER *Martha Anderson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Crosson*  
(STATE OR COUNTRY) *Missouri*

14. INFORMANT *Robert Johnston*  
(Address) *3576 block 18*

15. *Max C. Standiford*  
FILED **JUN 22 1931** 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 *6/8* 1931, to *6/19* 1931 that I last saw him *alive* on *6/19* 1931, and that death occurred, on the date stated above, at *3 PM*.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*108*  
*108*  
Lobar Pneumonia  
(duration) yrs. mos. ds. *11*  
CONTRIBUTORY (SECONDARY) *108*  
(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 *Egg*

(Signed) *E. H. Hays*, M. D.

, 19 (Address) *2140 Poplar, St. Louis*

\*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 *Washington Park Cem* DATE OF BURIAL *6/22/1931*

20. UNDERTAKER *Peoples Und. Co.* ADDRESS *311*

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

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