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

Do not use this space.

35083

File No. .....

Registered No. .....

1. PLACE OF DEATH

County: Monroe — Registration District No. 579

Township: Monroe — Primary Registration District No. 5716

City: Madison (No. ..... St. ..... Ward)

2. FULL NAME Mrs. Sarah Belle 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

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

5a. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND or~~ (OR) WIFE OF Dr. W. E. Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/10/1858

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	5	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at home

(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) Howard Co. Mo.

PARENTS

10. NAME OF FATHER Samuel A. Armstrong

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER Lucy A. Lynn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Va.

14. INFORMANT Dr. W. E. Johnson
(Address) Madison Mo

15. FILED 10/8 1931 W. W. Faubank REGISTRAR
Fred A. Thompson Reg

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 7 1931

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1931, to Oct 7, 1931, that I last saw her alive on Oct 7, 1931, and that death occurred, on the date stated above, at 3:40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Cerebral Thrombosis

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Mitral Regurgitation and High Blood Pressure (duration) Several yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) T. P. Turner M.D.

, 19 (Address) Madison, 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 Summit Hill Madison, Mo — DATE OF BURIAL 10/9 1931

20. UNDERTAKER Fred A. Thompson — ADDRESS Madison 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.