

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

Do not use this space.

37958 ✓

1. PLACE OF DEATH
 County Jackson Registration District No. 40.0
 Township Parame Primary Registration District No. 5553B
 City Little Bean (No. Jackson or Hann) St. _____ Ward _____

2. FULL NAME Cora Johnson
 (a) Residence, No. J.C. Home 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.

File No. _____
 Registered No. 224

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF single
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3.21 1858
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
(73) 3 8 2
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housekeeper
 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 _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 13. NAME unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 17. INFORMANT (ADDRESS) J.W. Hasbeller
J.C. Home
 18. BURIAL, CREMATION, OR REMOVAL PLACE Boysard Mo. DATE 11/27 1931
 19. UNDERTAKER (ADDRESS) E.D. Dickerson
Boysard Mo.
 20. FILED 11-27- 1931 William T. Fields Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 23 1931
 22. I HEREBY CERTIFY, That I attended deceased from 7-16, 1931, to 11-22, 1931.
 I last saw h. alive on 11-20, 1931. Death is said to have occurred on the date stated above, at 6:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral softening
 Date of onset _____
 Other contributory causes of importance:
g.c. g.w.c.
 Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. H. Schrock, M. D.
 (Address) Independence Mo.

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.

DEC 2 2 1931

