

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

Do not use this space.

1641

1. PLACE OF DEATH

56 County Lewis
3 Township Labille
3 City Labille (No.)

Registration District No. 479
Primary Registration District No. 4288

File No.
Registered No.
St. Ward)

2. FULL NAME

Rachel Juanita Johnson

(a) Residence, No. St. Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Negro 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) April 23-1916
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 15 9 5
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School Girl
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. attending school
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) Albia Iowa 2

FATHER 13. NAME Whisn Johnson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelbina Mo 11

MOTHER 15. MAIDEN NAME Mable Marshall

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

17. INFORMANT Mrs. Frank Campbell (ADDRESS) Labille Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Labille Mo DATE 1-31-1932

19. UNDERTAKER James T. Cochran (ADDRESS) Labille Mo

20. FILED 1/30 1931 J. L. Journ Registrar.

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 28 1932

2. I HEREBY CERTIFY, That I attended deceased from March 1931, to Jan. 28 1932

I last saw h. w. alive on Jan. 20 Feb. 1932. Death is said to have occurred on the date stated above, at 4 a. m.

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

Pulmonary Tuberculosis Date of onset

23A 3
Other contributory causes of importance: _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

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? _____ If so, specify _____

(Signed) W. M. Kim, M. D.
(Address) Labille Mo

N. B.—Every item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 4 1932

