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.

JUN 22 1932

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

15728

1. PLACE OF DEATH
32 County: Callaway
3 Township: Co Gravel
1 City: Calloway (No. ..... St. ..... Ward)

Registration District No. 260
Primary Registration District No. 4159
File No. .....
Registered No. .....

2. FULL NAME William D. 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 6 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)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE OF~~ Rose L. Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 1. 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	76	3	12	

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) Shelbyville
(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Lucedan Johnson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Lelon Johnson
(Address) Calloway Mo

15. FILED 5-14 1932 Winifred W. Mozer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13 1932

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1932, to May 13, 1932, that I last saw h. alive on May 13, 1932, and that death occurred, on the date stated above, at 7:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Occlusion of Coronary Artery
GHO
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) 3 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED ①
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) N. S. Gale, M. D
, 19 (Address) Auxvasse 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calloway Mo
DATE OF BURIAL 5-15 1932

20. UNDERTAKER Earl F. Nelson
ADDRESS Mokane Mo

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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)

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,19.....
that I last saw h..... alive on.....,19....., and that
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

CONTRIBUTORY.....
(SECONDARY)
.....(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?.....
(Signed)....., M. D
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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

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