

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

Do not use this space.

39330

1. PLACE OF DEATH

County Green Registration District No. 321
 Township Washington Primary Registration District No. 5425
 City (No. _____) St. _____ Ward _____

File No. 17
 Registered No. _____

2. FULL NAME

John E Johns
 (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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 20 1932

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

22. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1932 to Dec 21, 1932
 I last saw him alive on Dec 17, 1932 Death is said to have occurred on the date stated above, at 11:30 p.m.
 The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 4 17

Date of onset _____

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
 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 _____

107A
Pneumonia
 Other contributory causes of importance: (1)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

MOTHER FATHER
 13. NAME John Johns

Name of operation _____ Date of _____
 What test confirmed diagnosis? C. lysed Was there an autopsy no

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER FATHER
 15. MAIDEN NAME unknown

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)

MOTHER FATHER
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____

17. INFORMANT (ADDRESS) Johanna Johnson
Wagonville Mo.

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. J. Bayless M. D.
 (Address) Wagonville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Smith Cem DATE _____, 19____

19. UNDERTAKER (ADDRESS) Kelley & Terrell
Wagonville Mo.

20. FILED 7.9, 1933 Mr. G. C. Proctor Registrar.
Spa. office no. 2, 3.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 321
 Township Washington Primary Registration District No. 5445
 City (No. _____) St. _____ Ward _____

File No. 17
 Registered No. _____

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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) X 8-2 1849 X

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
4 4 17

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Furrier
 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) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED Feb 9 1933 Mrs G. C. Procter
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 20 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

_____ (Date of onset)

Other contributory causes of importance: 1070

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) _____, M. D.

(Address) _____

SUPPLEMENTARY

Springfield Mo R. 3.

REGISTRATION IS SMALL NOT RECORDED. A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

If the physician or other person furnishing the information should state EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-39330