

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

Do not use this space.

41445

1. PLACE OF DEATH

96 County St. Louis County
Township Central
City (No. St. Vincent's Sanitarium)

Registration District No. 289
Primary Registration District No. 6033
St. _____ Ward _____

File No. _____
Registered No. 349

2. FULL NAME

Harold James Johnson

(a) Residence. No. Central 22 St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 26 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 27, 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
33 1 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist 60
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Charles
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER John Johnson

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

12. MAIDEN NAME OF MOTHER Martha First

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

14. INFORMANT Sister Raphael, Supt.
(Address) St. Vincent's Sanitarium

15. FILED 12 19 32 Wm. D. S. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-10-1932

17. I HEREBY CERTIFY, That I attended deceased from 11/15/32 19 _____ to 12/10/32 19 32, that I last saw _____ alive on 12/10/32 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia.
Malaria.
(duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Wm. D. S. M. D.
11 19 32 (Address) St. Vincent's Sanitarium

*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 Centralia Ill. DATE OF BURIAL Dec 13, 1932.

20. UNDERTAKER C. F. Hoostree ADDRESS Centralia Ill.

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

JAN 5 1933

