

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

Do not use this space.

27241A

**1. PLACE OF DEATH**

County Linn  
Township Jacobs  
City Briggsville (No. ....)

Registration District No. 1102  
Primary Registration District No. 35870

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. 950 1/2 City St., ..... Ward, .....

(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 4 yrs. mos. ds., How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Walter Johnson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Not known</u>		
7. AGE YEARS <u>About 37</u>	MONTHS	DAYS
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>		11. Total time (years) spent in this occupation
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)

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 19 1933

22. I HEREBY CERTIFY, That I attended deceased from 8/15 1933 to 8-19 1933  
I last saw him alive on 8/19 1933 Death is said to have occurred on the date stated above, at 10:0 P.M.  
The principal cause of death and related causes of importance were as follows:  
Streptococcal infection of throat Date of onset about 12th

Other contributory causes of importance: Acute malaria

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Miss</u>
	13. NAME <u>Not known</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
	15. MAIDEN NAME <u>Not known</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT <u>Will Davis</u> (ADDRESS) <u>Briggsville</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Briggsville</u> DATE <u>Aug 20</u> 19 <u>33</u>	
19. UNDERTAKER <u>Friends</u> (ADDRESS)	
20. FILED <u>8/20</u> 19 <u>33</u> <u>Mrs T-R Cole</u> Registrar.	

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 William Hett (Signed) ..... M. D.  
(Address) Briggsville

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.

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