

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

Do not use this space.

29837
3763

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Stow Primary Registration District No. _____
City St. Louis Mo (No. 912 West 21) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Theo. D. Johnson
(a) Residence, No. 912 West 21 St 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 Wal. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 12 - 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
50 - 65

8. Trade, profession, or particular kind of work done, as planer, sawyer, bookkeeper, etc. Housewife

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) La.

13. NAME West Frazier

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

15. MAIDEN NAME Dont Senaw

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

17. INFORMANT S. M. Johnson (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge Lawn DATE 9-23 1933

19. UNDERTAKER Wayle Bros. (ADDRESS) 1708 Tracy

20. FILED 9-23 1933 M. M. Crowe Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-17 1933

22. I HEREBY CERTIFY, That I attended deceased from 9/17/33 to 9/17/33. I last saw her alive on 9/17/33. Death is said to have occurred on the date stated above at 10 in. The principal cause of death and related causes of importance were as follows:

Celulitis of left eye
Septicemia
Heart failure
1153
Other contributory causes of importance: abscess tooth
152B

Name of operation _____ Date of _____
What test conducted? _____ 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? No
If so, specify _____
(Signed) Theo. D. Johnson M. D.
(Address) 1612 E 17 St

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 should be given.

236
2
2
2

WHITE PRINTED WITH UNFADING INK—THIS IS A PERMANENT RECORD

