

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

Do not use this space.

252

85

263

1. PLACE OF DEATH

County Ruehan
Township St Joseph Mo
City State Hosp # 2

Registration District No. _____
Primary Registration District No. 1001

File No. _____
Registered No. 80
St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. _____
(Usual place of abode) Gallatin Mo Ward. _____

(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) Unknown
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1886
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 48 unknown
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Painter
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) Mo Wash
13. NAME Robert J. Johnson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo Wash
15. MAIDEN NAME Anna Pelcher
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wash
17. INFORMANT (ADDRESS) State Hospital Records St Joseph Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Gallatin DATE 1-22-34
19. UNDERTAKER (ADDRESS) H. Geo. Hoop Mo. Gallatin Mo.
20. FILED 1-21-34 John R. Bender Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 20 1934
22. I HEREBY CERTIFY that I attended deceased from Feb 11 1933 to Jan 20 1934
I last saw him alive on Jan 20 1934 Death is said to have occurred on the date stated above, at 1145 P
The principal cause of death and related causes of importance were as follows:
Robert Pneumonia Date of onset 1-17-34
Diphtheria 10 10 10 Date of onset 1-16-34
Other contributory causes of importance: _____
Name of operation none Date of _____
What test confirmed diagnosis? Lab Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury _____, 19____
Where did injury occur? no (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury none
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) W. H. Miller M. D.
(Address) State Hospital No 2

WHOLE PLAIN 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. 1934

