

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.

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

Do not use this space.

2186

FEB 27 1934

1. PLACE OF DEATH  
 County Pike Registration District No. 688  
 Township Pena Primary Registration District No. 4412  
 City Frankford (No. 3) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME James Drake Johnson  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 69 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 <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Widowed</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Unknown</u>		
7. AGE YEARS <u>69</u>	MONTHS	DAYS
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Laborer</u>		
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) <u>Frankford, Mo.</u>		
13. NAME <u>James Johnson</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
15. MAIDEN NAME <u>Unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT (ADDRESS) <u>J. C. Jackson</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Frankford, Mo.</u> DATE <u>Jan 31 1934</u>		
19. UNDERTAKER (ADDRESS) <u>J. M. Mason</u>		
20. FILED <u>Feb 5 1934</u> <u>Mattie Russell</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28 1934

22. I HEREBY CERTIFY That I attended deceased from Dec 24 1933 to Jan 28 1934  
 I last saw him alive on Jan 27 1934 Death is said to have occurred on the date stated above, at 7 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Solar pneumonia  
 Date of onset 108

Other contributory causes of importance:  
108

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) O. M. Anderson, M. D.  
 (Address) Frankford, Mo.

