

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

Do not use this space.

MAR 21 1935

4730

1. PLACE OF DEATH
 County Clay Registration District No. 198
 Township Swinging River Primary Registration District No. 201
 City Excelsior Springs (No. _____ St. _____ Ward _____)

2. FULL NAME Nell Joyce Johnston
 (a) Residence, No. St. Louis St. (South) Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. 4 mos. 12 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 24, 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
7 6 24

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. X

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. X

10. Date deceased last worked at this occupation (month and year) X 11. Total time (years) spent in this occupation. _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.

FATHER
 13. NAME Dr. Elmer Johnston
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) B Kansas

MOTHER
 15. MAIDEN NAME Hazel O. Childers
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas City, Kan.

17. INFORMANT (ADDRESS) Quinn Johnston

18. BURIAL, CREMATION, OR REMOVAL PLACE Masonic DATE Feb 20, 1935

19. UNDERTAKER (ADDRESS) Robert Hase Excelsior Springs

20. FILED 2-18-1935 Wm. R. McClellan Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18-1935

22. I HEREBY CERTIFY, That I attended deceased from 2-10, 1935, to 2-18, 1935
 I last saw him alive on 2-18, 1935. Death is said to have occurred on the date stated above, at 6 P m.
 The principal cause of death and related causes of importance were as follows:
Diphtheria
 Other contributory causes of importance:
poor

Name of operation X Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? X 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 X
 Nature of injury X

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) John Baird, M. D.
 (Address) Excelsior Springs

WRITE PLAINLY, 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.

