

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.

JUN 12 1935

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City..... **St. Louis Mo.** (No. **Barnes Hospital**)

18151

File No. **4495**  
Registered No. **4495**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME **Mabel M Johnson**

(a) Residence, No. **2121 Wiggins Ave.**, **N.R.** Ward. **Springfield Ill.**  
(Usual place of abode) (If nonresidential, 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Jag A Johnson**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan 12-1891**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
**44 4 7**

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

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) **Palmyra Ill**

13. NAME **P. D. Mahan**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Palmyra Ill**

15. MAIDEN NAME **Arma Binett**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Palmyra Ill**

17. INFORMANT (ADDRESS) **J. A. Johnson Springfield Ill**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Springfield Ill** DATE **May 22 1935**

19. UNDERTAKER (ADDRESS) **Albert St Hoppman 429 N. Edinburg**

20. FILED **May 20 1935** 19 **J. H. Brebeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5-19-1935**

22. I HEREBY CERTIFY, That I attended deceased from **5-14-1935** to **5-19-1935**

I last saw her alive on **5-19-1935** Death is said to have occurred on the date stated above, at **6:05 a.m.**

The principal cause of death and related causes of importance were as follows:

**tumor of Brain - Right frontal lobe - benign** Date of onset **1932**

Other contributory causes of importance: **540**

Name of operation **Cremation** Date of **5-18-35**

What test confirmed diagnosis? **fluid** Was there an autopsy? **yes**

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) **Leonard J. Fulkerson**, M. D.

(Address) **Barnes Hospital - St. Louis Mo.**

