

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

Do not use this space.

1. PLACE OF DEATH JUL 12 1935

County

Registration District No. **791**

Township

Primary Registration District No. **1003**

City *St. Louis, Mo.* (No. *Salvation Army Hospital*)

File No. **21463**

Registered No. **5413**

St. Ward

2. FULL NAME *Jesse Edward Johnson*

(a) Residence No. *374 a marine* St. Ward

St. *24* 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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 4, 1935*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Mo.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER *Bernadine Johnson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Farrisburg Illinois

14.

INFORMANT *Lillie Kittelsen*

(Address) *Salvation Army Hospital St. Louis*

15.

FILED JUN 21 1935

J. Brebeck
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 5 1935*

17.

I HEREBY CERTIFY, That I attended deceased from

19..... to..... 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at *10:37 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity (28 wks)

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *J. Johnson*

M. D.

, 19 (Address) *6305 S. Kingshighway*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Washington University Pathology Dept

6/5 1935

20. UNDERTAKER *Washington University Pathology Department*

ADDRESS

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.

RECORD

