

AUG 26 1935

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

Do not use this space.

28543

1. PLACE OF DEATH

County *Jefferson* Registration District No. *460*  
Township *Davis* Primary Registration District No. *4623*  
City *Higginsville* (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

2. FULL NAME

*Samiah Johnson*  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (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 <i>Female</i>	4. COLOR OR RACE <i>Colored</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>John Johnson</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>1866</i>		
7. AGE	YEARS	MONTHS
<i>14</i>	<i>69</i>	
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>House work</i>		
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) <i>Dem.</i>		
13. NAME <i>Albert Brown</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Dem.</i>		
15. MAIDEN NAME <i>unknown</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>unknown</i>		
17. INFORMANT (ADDRESS) <i>John Johnson Higginsville</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Colored</i> DATE _____ 19____		
19. UNDERTAKER (ADDRESS) <i>Asst. S. Higginsville, Mo.</i>		
20. FILED <i>July 14, 1935 W. G. McE Registrar.</i>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 12, 1935*

22. I HEREBY CERTIFY, That I attended deceased from *June 12, 1935* to *July 12, 1935*  
I last saw her alive on *July 2, 1935* Death is said to have occurred on the date stated above, at *11:45 A.M.*  
The principal cause of death and related causes of importance were as follows:  
*Chronic Myocarditis, died suddenly while eating.*

Other contributory causes of importance *Autopsy* Date of onset *7-2-35*

Name of operation *None* Date of \_\_\_\_\_  
What test confirmed diagnosis? *Physical* 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? \_\_\_\_\_ (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) *W. A. Bracklein*, M. D.  
(Address) *Higginsville, Mo.*

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.

WHITE PANEL, WITH CONTINUING NUMBER, IS A PERMANENT RECORD

