

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.

SEP 25 1935

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

Do not use this space.

31509

1. PLACE OF DEATH

County *St. Louis*Registration District No. *1170*Township *Central*Primary Registration District No. *6248H*City *Richmond Heights*St. *St. Marys Hospital*

File No. _____

Registered No. *179*

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *27198 Edge Ave* 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>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *George Johnson*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 14, 1867*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<i>7</i>	<i>68</i>	<i>5</i>	<i>21</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *At home*

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) *Missouri*13. NAME *Don't know*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*15. MAIDEN NAME *Don't know*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*17. INFORMANT *Mrs. George J. Johnson*
(ADDRESS) *2831 St. Albans Rd*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Higginsville Mo.* DATE *Sept 7 1935*19. UNDERTAKER *Geo. L. Pleitseh Inc.*
(ADDRESS) *5966 Eastern Ave*20. FILED *Sept 6 1935* *Tertrude Porter*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 5 1935*22. I HEREBY CERTIFY That I attended deceased from *Sept 1 1935* to *Sept 5 1935*I last saw her alive on *Sept 5 1935*. Death is said to have occurred on the date stated above, at *5:20 P.M.*

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

Peritonitis (Abdominal) Date of onset *9-1-35*

Other contributory causes of importance:

*Ruptured, gangrenous Appendix*Name of operation *Appendectomy* Date of *Sept 2*What test confirmed diagnosis? _____ 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) *C. P. Sterling MD* M. D.(Address) *2205 No. 4 So. Rd R & S. Co. Mo.*

