

MAY 7 1937 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County
Township
City *St. Louis, Mo.* (No. *City Hospital #2*)

Registration District No. **791**
Primary Registration District No. **1003**

File No. **14087**
Registered No. **3583**
St. Ward)

2. FULL NAME *Leivinda Johnson*

(a) Residence, No. *2477 Compton* St., **21** 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *col.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 22, 1878*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 7 2

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

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Carole Barnes 2477 Compton 3rd floor*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Herculeum* DATE *4/2/37*

19. UNDERTAKER (ADDRESS) *Resurrection Home 2631 Market St*

20. FILED *J. Bredek* Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar. 24, 1937*

22. I HEREBY CERTIFY, That I attended deceased from *1-28-1937* to *3-24-1937*

I last saw *her* alive on *3-23-1937*. Death is said to have occurred on the date stated above, at *5:30 P.M.*

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

Mites of pusillorum
Chromia B. Rudington

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

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?
If so, specify *J. H. Arkusson*, M. D.
(Signed) *J. H. Arkusson*
(Address) *3200 S. Flannery Ave*

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.

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APR 2 1937

