

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

Do not use this space.

1. PLACE OF DEATH **AUG 31 1937**  
 County **Cedar** Registration District No. **875**  
 Township **Nebraska** Primary Registration District No. **875**  
 City **Nevada** (No. **3039**) Registered No. **193**  
 State **Mo.** Ward **1**

2. FULL NAME **Joice Davis 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**

**MEDICAL CERTIFICATE OF DEATH**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **About 1871**

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<b>about 65</b>	<b>9</b>	<b>21</b>	

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

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 18 - 1937**

22. I HEREBY CERTIFY, that I attended deceased from **July 17, 1937** to **July 18, 1937**.  
 First saw her alive on **July 17, 1937** Death is said to have occurred on the date stated above, at **6:21** a.m.  
 The principal cause of death and related causes of importance were as follows:  
**Acute Indigestion, with myocarditis of July 17, 1937, two months standing. Gastro-enteritis causing indigestion.**  
 Other contributory causes of importance: **None**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Hannibal Mo**

13. NAME **Not known**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

15. MAIDEN NAME **Not known**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

17. INFORMANT **Bessie Green**  
 (ADDRESS) **607 Soak**

18. BURIAL, CREMATION, OR REMOVAL **Maplewood Cemetary** DATE **7-20 1937**

19. UNDERTAKER **Terry Funeral Home**  
 (ADDRESS) **Nevada Mo**

20. FILED **7/21 1937** **M. C. Cichinger**  
 Registrar

Name of operation **None** Date of \_\_\_\_\_

What test confirmed diagnosis? **Exam** Was there an autopsy? **no**

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 **None**  
 (Signed) **W. R. Love**, M. D.  
 (Address) **Nevada, 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.

1180

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

285-92  
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875  
(b) Township \_\_\_\_\_ Primary Registration District No. 3039 Registered No. \_\_\_\_\_  
(c) City Nevada (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Joseph Davis Johnson  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 18 1937  
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
65 9 21

Date of onset  
acute indigestion  
with myocarditis of two  
months standing  
Gastro Enteritis  
Other contributory causes of importance:  
causing indigestion

8. Trade, profession, or particular kind of work done, as a driver, bookkeeper, etc.  
9. Industry or business in which work was done, as a 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 COUNTY)

FATHER 13. NAME  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_\_\_

Name of operation g3a 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 \_\_\_\_\_

(Signed) W. S. Love, M. D.  
(Address) Nevada

SUPPLEMENT

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

5-22-59