

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

Do not use this space.

1257

**1. PLACE OF DEATH**

County Hunny  
Township Clinton  
City Clinton (No.       )

Registration District No. 347  
Primary Registration District No. 3018

File No.         
Registered No. 22  
St.        Ward       

**2. FULL NAME**

(a) Residence. No.        St.        Ward         
(Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Cal 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 6 / 1871

7. AGE YEARS 57 MONTHS 5 DAYS 29 IF LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Taylor  
(b) General nature of industry, business, or establishment in which employed (or employer) B. F. Johnson  
(c) Name of employer B. F. Johnson

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callaway Missouri

10. NAME OF FATHER David Keener

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) David Keener

12. MAIDEN NAME OF MOTHER David Keener

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) David Keener

14. INFORMANT (Address) Miss Jui Budgett Clinton Mo.

FILED Jan 26 1929 Dr. E. C. Peeler REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-25 1929

I HEREBY CERTIFY, That I attended deceased from       , 1929, to       , 1929, that I last saw h.        alive on       , 1929, and that death occurred, on the date stated above, at        m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Respiration (Found dead in Bed)  
97 A

CONTRIBUTORY (SECONDARY) Valvular heart disease

(duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? POA

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?        DATE OF       

WAS THERE AN AUTOPSY?       

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) G. Swisher M. D.

At Clinton Mo. 1929 (Address) Clinton Mo.

\*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 Clinton Mo. DATE OF BURIAL Jan 26 1929

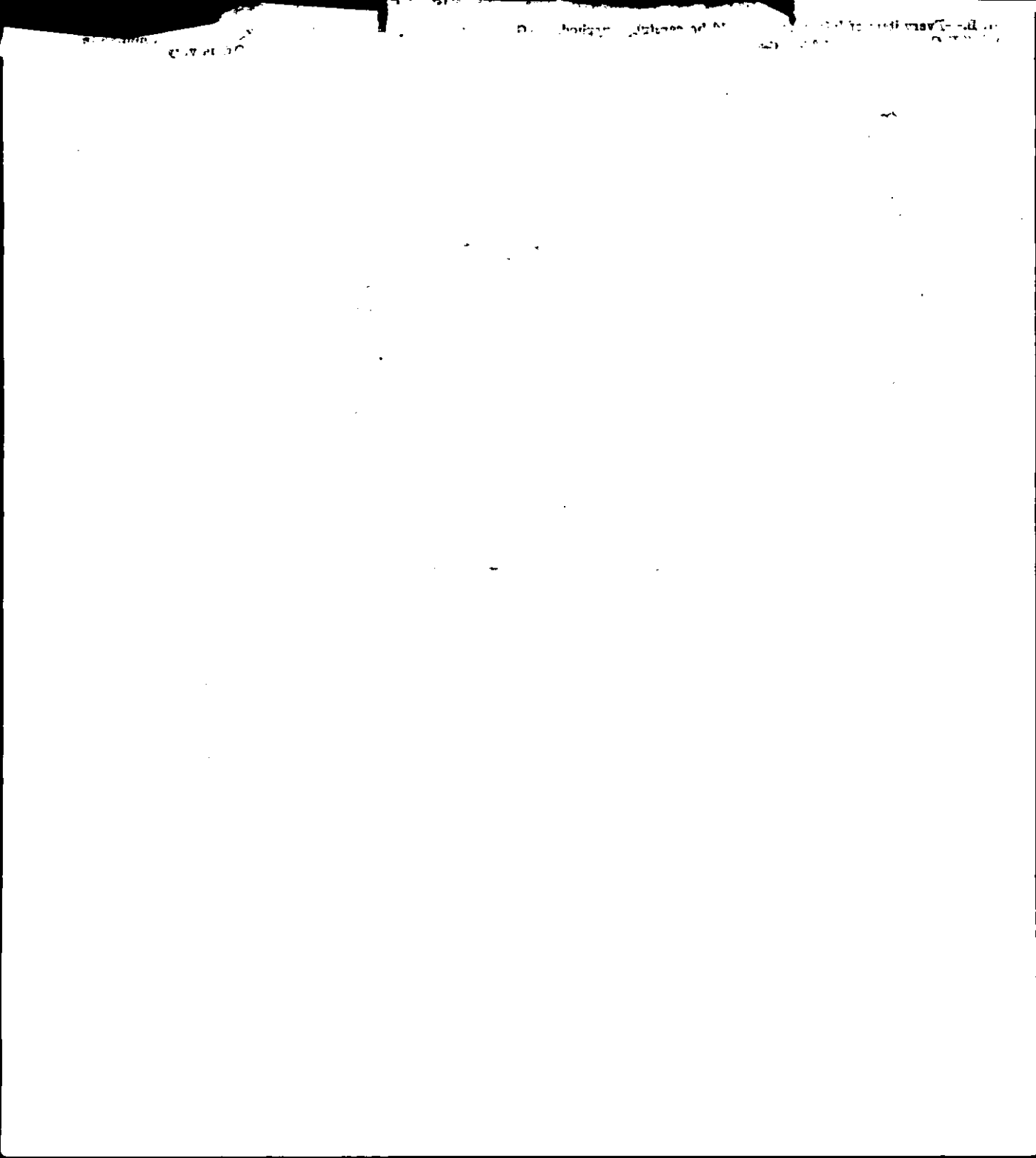
20. UNDERTAKER Trans W. K. Kasper & Co. ADDRESS       

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' SIGNATURES SHOULD BE IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. WRITE FULLY. DO NOT WRITE INK—THIS IS A P...

1929  
7442

239

31



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Henry Registration District No. 347 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3018 Registered No. 12  
 City Clinton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** B. F. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M. 4. COLOR OR RACE B. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S.  
(use the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 6 - 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
57 5 6 1

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) yrs. mos. da.  
 (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) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

**14.**

INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

**15.**

Jan. 26 1929 Dr. E. C. Peeler  
 FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 20 1929 19 \_\_\_\_\_

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19 \_\_\_\_\_, to \_\_\_\_\_, 19 \_\_\_\_\_, (that I last saw h. \_\_\_\_\_ since on \_\_\_\_\_, 19 \_\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 19 \_\_\_\_\_ (Address)

\*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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

19 \_\_\_\_\_

REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

5-12-57