

OCT 28 1930

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

Do not use this space.

29698

1. PLACE OF DEATH

County Grundy  
Township  
City Tranton (No. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)

Registration District No. 330  
Primary Registration District No. 3017

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

2. FULL NAME

Eliakim K Johnson

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. Burnsprings Mo  
(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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)  
married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Eliza Ann Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 20 1836

7. AGE

YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
93      8      12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer  
(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) Tenn.

10. NAME OF FATHER

Gas Johnson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER

Margaret Cox

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tenn.

PARENTS

14. INFORMANT Eliza Ann Johnson

(Address) Burnsprings Mo

15. Sept 2, 30

E. A. Druffly  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug. 9 1930 to Sept 2 1930. that I last saw him alive on Aug 27 1930 and that death occurred, on the date stated above, at 1:15 A. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Myocarditis Chronic  
1868  
1948  
93E (duration) 10 yrs. mos. ds.

CONTRIBUTORY Broken femur  
(SECONDARY) by fall, accidental (duration) yrs. mos. ds. 21

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: ✓

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) U. C. Weston, M. D.

9-2-1930 (Address) Galt, 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

Campground Cem.

DATE OF BURIAL

Sept 3 1930

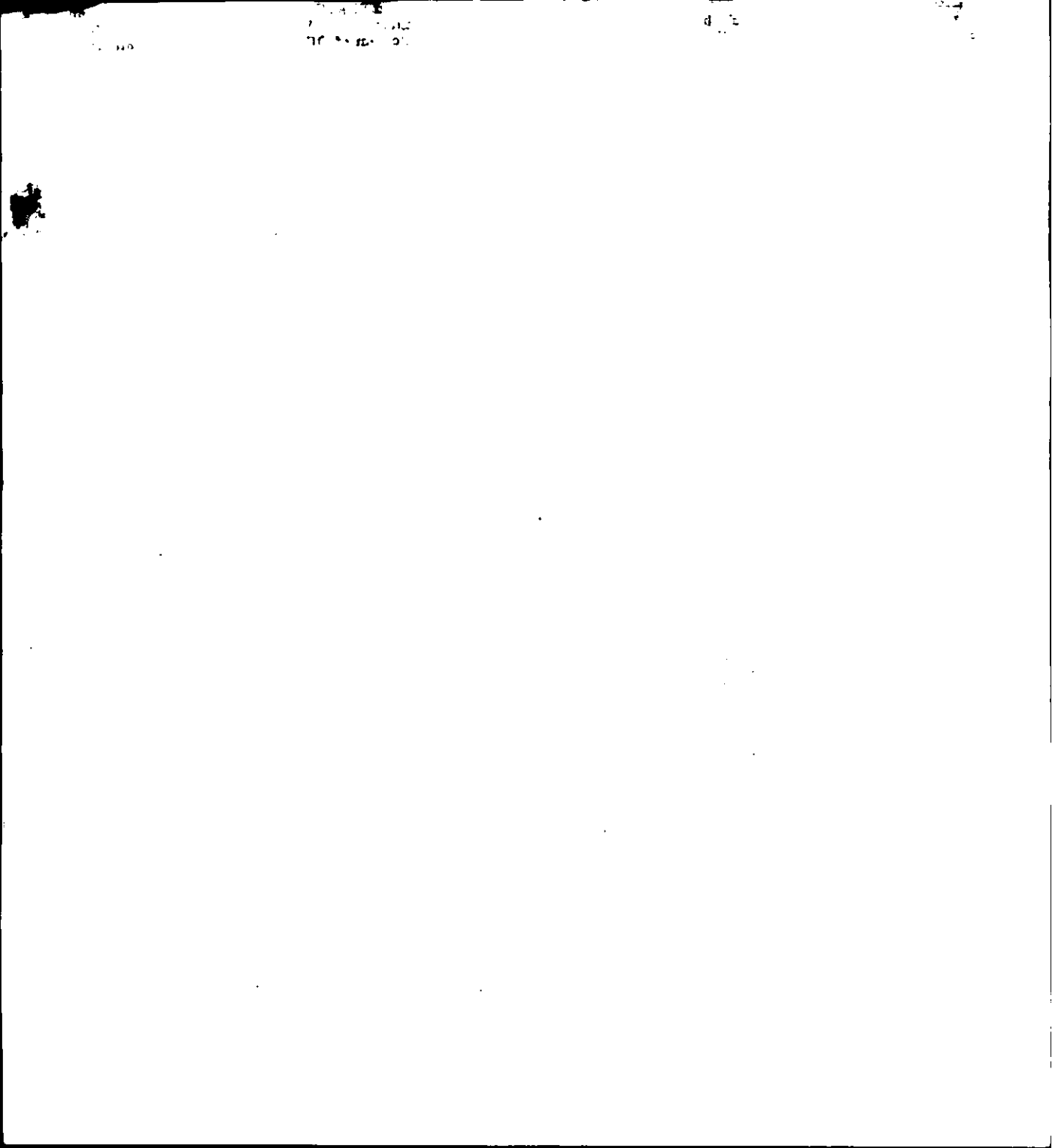
20. UNDERTAKER

O. K. Payne & Son

ADDRESS

Galt 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.



**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 Lundy  
Township Trenton  
City Trenton (No. .... St. .... Ward)

Registration District No. 330  
Primary Registration District No. 3017

File No. ....  
Registered No. ....

**2. FULL NAME**

Elakim K. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work  
(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.**

FILED Nov 29 1930 E. A. Duffey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds. Broken at home, just his balance  
BY fall - accidental (duration) yrs. mos. ds. at home, just his balance

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds. at home, just his balance

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? 5

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) W. Clifton, M. D.

11-28, 1930 (Address) Galv 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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B. Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1930

29698