

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

Do not use this space.

9463

**1. PLACE OF DEATH**

County Berns  
Township Wheeler  
City Wheeler (No. \_\_\_\_\_)

Registration District No. 1168  
Primary Registration District No. 5042

File No. \_\_\_\_\_  
Registered No. 6  
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.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

M

**4. COLOR OR RACE**

W

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

Widowed

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

Widowed

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

April 26 1884

**7. AGE**

YEARS MONTHS DAYS  
87 10 11

IF LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

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

Harness Maker

(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)

Mo.

**10. NAME OF FATHER**

John W. Johnson

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Mo.

**12. MAIDEN NAME OF MOTHER**

Not Known

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Mo.

**14.**

INFORMANT  
(Address)

A. C. Johnson  
Wheeler Mo.

**15.**

FILED

Apr 1, 1929 E. Edmondson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

Mar. 18 1929

**17.**

I HEREBY CERTIFY, That I attended deceased from March 1, 1929 to March 15, 1929  
that I last saw him alive on March 14, 1929, and that death occurred, on the date stated above, at W. M.

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

Endocarditis chronic  
9VH  
(duration) 2 yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

**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) O. W. McCall

, 19 (Address) Wheeler 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**

Cassville Cem.

Mar 17 1929

**20. UNDERTAKER**

**ADDRESS**

Rogers and

Wheeler

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.

