

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

Do not use this space.

33959

## 1. PLACE OF DEATH

County *St. Genevieve*Registration District No. *780*Township *Platte Genevieve*Primary Registration District No. *6020*City *St. Genevieve* (No. *57* St. *Ward*)

## 2. FULL NAME

*Katie Johner*(a) Residence. No. *57* 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

*Female*

## 4. COLOR OR RACE

*white*

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

*single*

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

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

*Sept 4 1930*

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

day, ..... hrs.

or ..... min.

*0**1**20*

## 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)

*St. Genevieve Missouri*

## PARENTS

## 10. NAME OF FATHER

*Peter Johner*

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

(STATE OR COUNTRY)

*St. Genevieve Missouri*

## 12. MAIDEN NAME OF MOTHER

*Katie Haller*

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

(STATE OR COUNTRY)

*St. Genevieve Missouri*

## 14.

INFORMANT

(Address)

*Peter Johner St. Genevieve Mo*

## 15.

FILED

*Oct 25 1930 T. W. Douglas*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

*Oct 24 1930*

## 17.

I HEREBY CERTIFY, That I attended deceased from *Oct 24* to *Oct 24*, 19*30*, that I last saw him alive on *Oct 24*, 19*30*, and that death occurred, on the date stated above, at *3:30 p.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Bronchus Pneumonia*

CONTRIBUTORY (SECONDARY)

*Pertussis*(duration) ..... yrs. .... mos. *1* ds.(duration) ..... yrs. .... mos. *10* ds.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *V*DID AN OPERATION PRECEDE DEATH? *No* DATE OF *-*WAS THERE AN AUTOPSY? *No*WHAT TEST CONFIRMED DIAGNOSIS? *Expt + Expt*(Signed) *D. J. Clapp*

M. D.

*Oct 25 1930 (Address) St. Genevieve 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

*Osage Mo**10/25 1930*

## 20. UNDERTAKER

## ADDRESS

*John Bash St. Genevieve Mo*

