STATE OF MINNESOTA

Division of Vital Statistics

8691

CERTIFICATE OF DEATH

Reg. District No. ..... No. in Registration Book 200
(Above numbers to be filled in only by local registrar or his deputy.)

1 PLACE OF DEATH

County Nicollet

Township or Village ....

or City St. Peter No. State Hospital St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Johnson

(a) Residence. No. St. Paul, Minn. St. ....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 28 ds. How long in U. S., if nonresident give city or town and State) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (WRITE the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, Profession, or particular kind of work dressmaker

(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) Norway

PARENTS

10 NAME OF FATHER Andrew Vihus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Gunhild Hegna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant (Address) Hospital records, St. Peter, Minn.

15 Filed 11/21, 1922 F. P. Strathern REGISTRAR

Received DEC 12 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 26 1922 to Nov. 19, 1922

that I last saw h.. alive on Nov. 18, 1922

and that death occurred on the date stated above, at 1:15P a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Enteros - Colitis

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examin.

(Signed) Mary E Bowers, M. D.

(Address) 11/19/22 St. Peter, Minn.

*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. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Hospital Cemetery	11/21 1922

20 UNDERTAKER ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be complete and correct. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be readily understood. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING