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

Do not use this space.

8167

1. PLACE OF DEATH
County Jackson — Registration District No. 399
Township Kaw — Primary Registration District No. 1082
City Kansas City (No. St Marys Hosp. St. ..... Ward)

File No. ..... Registered No. 1020

2. FULL NAME Frank E Johnson
(a) Residence. No. 1232 Washington St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 35 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): Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 5 - 1870

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
57	1	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Flagman
(b) General nature of industry, business, or establishment in which employed (or employer): Mo Pac
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo -

PARENTS
10. NAME OF FATHER: Edw. Johnson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Conn -
12. MAIDEN NAME OF MOTHER: Catherine Bowers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Maine -

14. Mrs Frank Killian INFORMANT (Address) Chillicothe Mo -

15. FILED 3/10, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 8 1927

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner ....., 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:
Acute Cellulitis of scalp (Septicaemia — Streptococcic) 131 / 1571 / 36
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis Interstitial (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 129a
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Chas S Nelson, M. D
3-8, 1927 (Address) Deputy Coroner

*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: Maple Hill Cemetery Kans. City Kans.
DATE OF BURIAL: 3/10/27

20. UNDERTAKER: The Freeman Mortuary
ADDRESS: 3146 Main