

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

Do not use this space.

11900

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 608 East 8th)

Registration District No. 399
Primary Registration District No. 7002

File No. 1696
Registered No. 1696
St. _____ Ward _____

2. FULL NAME Mary Jane Johnson

(a) Residence No. 608 East 8th 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby 17, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 2 6

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(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) Missouri

10. NAME OF FATHER Edmon Richards

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Hannah Campbell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

14. INFORMANT Christian Johnson (Address) 608 East 8th St.

15. FILED 4/25 27 Mrs. Corone REGISTRAR act

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 23 1927

17. Deputy Coroner 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:
Accidental - Fractured left hip - Fall

1965 (duration) 1 yrs. mos. ds.
7.56 Chronic Myocarditis (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHEN AND WHERE CONTRACTED _____ (IF NOT AT PLACE OF DEATH)
1875 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? History & symptoms
(Signed) Chas. Nelson, M. D.

4-27-27 (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 Massville, Mo DATE OF BURIAL 4/25 1927

20. UNDERTAKER Stine & M. Clure ADDRESS 927 Oak

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.

WHITE PRINT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

