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

Do not use this space.

21657

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.: [illegible]
Township: Kaw — Primary Registration District No.: 1002 — Registered No.: [illegible]
City: Kansas City (No. Kansas City General Hospital St. ..... Ward)

2. FULL NAME: James Johnston
(a) Residence. No. 43rd Indiana Ward. 16
(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: male
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): Aug 12, 1874

7. AGE: Years 52 — Months 11 — Days 17 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(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): Leavenworth Co. Hoyt Kansas

PARENTS
10. NAME OF FATHER: Wm W. Johnston
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Scotland
12. MAIDEN NAME OF MOTHER: Jessie Hare
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Scotland

14. INFORMANT: Wm W. Johnston
(Address) 1025 Ford ave. K.C.K.

15. FILED 8/1, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 29 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 6:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suicide - Cut throat
164
171
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Chas. Nelson, M. D.
7-29, 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: Mt. Muncie Leavenworth Kas — DATE OF BURIAL: Aug. 1 1927

20. UNDERTAKER: Eylar Bros — ADDRESS: K.C. Mo.

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.