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

Do not use this space.

1. PLACE OF DEATH U.S.V.Hosp. #67
County Jackson — Registration District No. 399 — File No. 24077
Township Kaw — Primary Registration District No. — Registered No. 205
City Kansas City, Mo (No. U.S. Veterans Hosp. St. Ward)

2. FULL NAME Johnson, Jeff — C-1 256 429
(a) Residence. No. 1935 N 13th St. St., Ward.
(Usual place of abode) Kansas City, Kansas. (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-19-1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	40	4	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter & Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Gallatin
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown

14. INFORMANT Hospital Records
(Address) Veterans Hospt

15. FILED 7/27, 1928 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 1928

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1928 to July 25, 1928 that I last saw him alive on July 25, 1928, and that death occurred, on the date stated above, at 4:15 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Meninges.
23A
24A
31
(duration) yrs. mos. Few ds.

CONTRIBUTORY (SECONDARY) Tuberculosis, pul. chr. advanced.
Probably (duration) several yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Unknown
O DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory & X-ray
(Signed) W.E. Chambers, M.D
F.S. W.E. CHAMBERS, Medical Officer in Charge.
(Address) U.S.V.Hosp. #67, Kansas City, Mo.
7/25/28

*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 Hope — DATE OF BURIAL 7/27/1928
20. UNDERTAKER The Taylor Funeral Home — ADDRESS

N. B.—Every item of information should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be [illegible] exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 0002 Registered No. 32.03

City K. City No....., ... St. .....Ward)

2. FULL NAME Johnson, Jeff

(a) Residence. No..... 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: M

4. COLOR OR RACE: W

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

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

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

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
(Address)

15. FILED 2/27, 1928 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 19 28

17. 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:

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

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....M. D
, 19 (Address)

*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 19

20. UNDERTAKER | ADDRESS K C Mo

SUPPLEMENTARY

N.B.—Every item of information should be correctly supplied. Do not omit any item of which you do not know the exact date. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

LLOHE-S