

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

Do not use this space.

36194

1. PLACE OF DEATH

County Jackson
Township Kearney
City Kansas City (No. Research)

Registration District No. 399
Primary Registration District No. 75092

File No. _____
Registered No. 650
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1615 Reynolds St., _____ Ward. Kansas City Kansas
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Whit. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 30 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 7 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Zanesville (STATE OR COUNTRY) Ohio

10. NAME OF FATHER David H. Johnson

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

12. MAIDEN NAME OF MOTHER Lucille S. Spann

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

14. INFORMANT David H. Johnson (Address) 1615 Reynolds

15. FILED 11/3, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 11 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930, to Nov 11, 1930, that I last saw her alive on Nov 11, 1930, and that death occurred, on the date stated above, at 6:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Infectious laryngo-tracheo-bronchitis
106A (duration) yrs. mos. 4 ds.

CONTRIBUTORY none (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home.
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Nov 8-30

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) San E. Roberts M. D.
11-19-30 (Address) 1110 Prof Bldg Kern

*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 Int. Imrich Mausoleum DATE OF BURIAL 11-14-30

20. UNDERTAKER Fairweather-Werner ADDRESS 14 M 7th St. 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.

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