

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

Do not use this space.

16467

1952

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City No. 2409 Linwood

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Helen E. Johnson

(a) Residence. No. 2409 Linwood Blvd. St. Ward. \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Fe.

**4. COLOR OR RACE**

White

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

Widowed

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

James R. Johnson

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

March 22, 1847

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

86

1

11

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

None

(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)

Zanesville Ohio

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Geo. Dille

Ohio

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Mary Shacklett

Va.

**14. INFORMANT**

Chas. L. Johnson  
(Address) 2409 Linwood Blvd.

**15. FILED**

May 5 33 1952

M. M. Crowe  
Asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** May 3 1933

**17. I HEREBY CERTIFY, That I attended deceased from** April 25, 1933, **to** May 3, 1933, **that I last saw him alive on** May 20, 1933, **and that death occurred, on the date stated above, at** 10:10 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral hemorrhage

8 20 (duration) yrs. mos. 8 ds.

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH. \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) Jay A. Smith, M. D.

5/5 1933 (Address) 1007 Central Ave

\*State the DISEASE CAUSING DEATH, or in case of trauma, the CAUSE OF DEATH. (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Cal Shouat K.C.Ks.

May 6 1933

**UNDERTAKER**

**ADDRESS**

Lawweather-Werner

K.C.Ks.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

