

REC'D SEP 13 1938

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

27961

Do not use this space.

## 1. PLACE OF DEATH

(a) County Johnson Registration District No. 395  
(b) Township Indian Primary Registration District No. 1002  
(c) City Kansas City (d) Street No. 72 C Gen Hosp Registered No. 3272  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

(a) Residence, No. 16 W 7th St St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James J. Johnson  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 4 1905  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 32 7 28  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W W  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Colo

FATHER 13. NAME unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Colo

MOTHER 15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Colo

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL K.C. Gen Hosp

19. FUNERAL DIRECTOR (ADDRESS) John B. Apostol

20. FILED Aug 18 1938 M.M. Brown Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-17 1938

22. I HEREBY CERTIFY, That I attended deceased from 8-14 1938 to 8-17 1938

First saw alive on 8-17 1938. Death is said

to have occurred on the date stated above, at 6:15 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Thrombosis;  
Encephalomalacia

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? 1

If so, specify.....

(Signed) P. J. De Maner M. D.

(Address) Gen Hosp

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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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**