

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

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

1. PLACE OF DEATH: Jackson  
(a) County \_\_\_\_\_  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: A.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: 2 days  
In this community: 35 yrs (Specify whether years, months or days)

8. (a) PRINT FULL NAME EDWARD JOHNSON 525  
3. (b) If veteran, name war: no 3. (c) Social Security No. no

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Belle Johnson 6. (c) Age of husband or wife if alive Sec years  
7. Birth date of deceased: Mar-4-1860  
(Month) (Day) (Year)

8. AGE: Years 80 Months no Days 7 If less than one day hr. min.

9. Birthplace Norway (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business  
12. Name John Johnson  
13. Birthplace Norway (City, town, or county) (State or foreign country)  
14. Maiden name Mazha  
15. Birthplace Norway (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harriet Alexander  
(b) Address 108 Douglas, Warren St  
17. (a) burial (b) Date thereof: Mar-13-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. P. Doherty  
(b) Address 1415 72 15  
19. (a) Mar 12, 1940 (b) M. D. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 622 Benton (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 11th  
year 1940 hour 10 minute 10 A.M. M.

21. I hereby certify that I attended the deceased from 3-9-40, 19\_\_\_\_, to 3-11-40, 19\_\_\_\_;  
that I last saw h im alive on 3-11-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decampensation  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy None

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature G. D. ... M.D. (M. D. or other) \_\_\_\_\_  
Supt. K.C. Gen. Hospital, K.C. Mo.  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WHILE FLAINLY--USE UNFADING BLACK INK--MAKE 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.

1 X1811

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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.....

*H. P. Doshier*

Licensed Embalmer No.....

1166

P. O. Address.....

1415 E 15

**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.**