

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17521

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2048

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5629 Olive Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ----- (Specify whether
In this community 24 Years
years, months or days)

3. (a) PRINT FULL NAME Mr. Frank H. Johnson 525

8. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Nancy B. Johnson 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased December 19 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>4</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation Employee

11. Industry or business Standard Oil Company

12. Name Reverend William Johnson

13. Birthplace Maine
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Paine

15. Birthplace Boston Massachusetts
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nancy B. Johnson
(b) Address 5629 Olive Street

17. (a) Burial (b) Date thereof May 18, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meadville, Missouri

18. (a) Signature of funeral director D. H. Newcomer, Son

(b) Address 1401 Brushy Creek Blvd.

19. (a) May 17, 1940 (b) M. M. Brown
(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. 5629 Olive Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ----- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16th
year 1940 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from May 9, 1940
to May 16, 1940

that I last saw him alive on May 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration about 1 year

Due to Chronic Nephritis

Due to Arteriosclerosis 131

Other conditions Hypertension
(Include pregnancy within 4 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

(e) Means of injury 3

While at work? _____ (Specify type of place)

23. Signature A. B. Boyer, D.O. (M. D. or other) _____

Address 1009 E. 47th St. No. 766 Date signed May 16, 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1007. Sect. 43 of Rules

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 C. Hervey Gussenberg
Licensed Embalmer No. 4070
P. O. Address A. C. Mo.

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.