S. No. 2
—11-10-39
v. 5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20975

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2592

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 General Hospital # 2. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-25-40 (Specify whether

In this community 27 years years, months or days)

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. 1705 E.13th.St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Granville Johnson 525

3. (b) If veteran, name war None

3. (c) Social Security No. 487-03-4555

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Monett Johnson

6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased November 2, 1907 (Month) (Day) (Year)

8. AGE: Years 32 Months 7 Days 21 If less than one day ..... hr. ..... min.

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

10. Usual occupation Laborer WPA

11. Industry or business

FATHER
12. Name Lee Johnson
13. Birthplace (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Josephine Bailey
15. Birthplace (City, town, or county) Texas (State or foreign country)

16. (a) Informant Josephine Hester

(b) Address 1705 East 13th St.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6/27/40 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Watkins Bros.

(b) Address 1729 Lydia

19. (a) June 26, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June, day 23d year 1940 hour 3 minute 40 P.M.

21. I hereby certify that I attended the deceased from ....., 19.... to ....., 19....; that I last saw him alive on ....., 19....; and that death occurred on the date and hour stated above.

Immediate cause of death Sub Dural Hemstorm

Due to Lyt Concussion Hemstorm of Brain

Due to 175 12

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) Homicide

(b) Date of occurrence Do not know 6-25-40

(c) Where did injury occur? Kansas City Jackson Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Ma House - 1121 Woodland (Specify type of place)

While at work? Injured (e) Means of injury Fight

23. Signature Russell W. Kerr (M. D. or other)

Address Kerr Date signed

(Licensed Embalmer's Statement on Reverse Side)

mc

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. H. West

Licensed Embalmer No. 2719

P. O. Address 1905 Vine St

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.