FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1448

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 408

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 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-12-41-1-12-41 (Specify whether years, months or days)

In this community 25 Minutes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 4

(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL") 0

(d) Street No. Gen. Hosp. #2 1211 East 23rd (If rural, give location)

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

3. (a) PRINT FULL NAME Infant Johnson

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased 1 (Month) 12 (Day) 1941 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day ..... hr. 25 min.

9. Birthplace Kansas City (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation None

11. Industry or business .....

FATHER
12. Name James Harston
13. Birthplace ..... (City, town, or county) Tenn. 1 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Johnson
15. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address Gen. Hosp. # 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-41 (Month) (Day) (Year)

(c) Place: burial or cremation Lead Co

18. (a) Signature of funeral director Wm A Johnson

(b) Address 12 C Gen Hosp

19. (a) Jan 29 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 12 year 41 hour 3 minute 25 P. M.

21. I hereby certify that I attended the deceased from 1-12- 1941, to 1-12- 1941; that I last saw him alive on 1-12- 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Premature	
Due to 159	
Due to	
Other conditions (Include pregnancy within 3 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? ..... (Specify type of place)

While at work? ..... (e) Means of injury △

23. Signature [signature] (M. D. or other)

Address Gen. Hosp. #2 Date signed 1-14-41

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—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.

I X19511

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.