

No. 2
4-13-40,
5-17-39
I X2315

Registration District No. **399**

Primary Registration District No. **1002**

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

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 **Kansas City General Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **15 Minutes**
(Specify whether)

In this community **25 Years**
years, months or days

3. (a) PRINT FULLNAME **Mr. Anton Johnson**

3. (b) If veteran, name war **No War Veteran** (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. Helga Johnson** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **December 24 1873**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	1	7	hr. _____ min. _____

9. Birthplace **Ansøtor Denmark**
(City, town, or county) (State or foreign country)

10. Usual occupation **Contractor**

11. Industry or business **General**

MOTHER FATHER { 12. Name **Unknown Johnson**

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

14. Maiden name **Unknown**

15. Birthplace **Denmark**
(City, town, or county) (State or foreign country)

16. (a) Informant **Carl A. Johnson**

(b) Address **4801 Brooklyn**

17. (a) **Burial** (b) Date thereof **Feb. 3, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills Cemetery**

18. (a) Signature of funeral director **D. H. Newcomer's Sons**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **2-3-41** (b) **M. M. Crause**
(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. **4801 Brooklyn Ave.**
(If rural, give location)

(e) If foreign born, how long in U. S. A. **50 Years** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **1st**
year **1941** hour **12** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **19** to **19** that I last saw **Deputy Coroner** alive on **19** and that death occurred on the date and hour stated above.

Immediate cause of death **Lung & Heart Disease**

Due to **Brain**

Due to _____

Other conditions **Brain**
(Include pregnancy within 3 months of death)

Major findings: **Of operations**

Of autopsy _____

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide **Not given**

(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 **3**

23. Signature **D. H. Newcomer's Sons** (M. D. or other) _____
Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 Hervey Quisenberry

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 500

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME..... Anton Johnson

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

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 2/3/41 (Date received local registrar) (b) R. W. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No. 4801 Brooklyn (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Feb. day 1st year 1941 hour..... minute..... 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 Laceration & hemorrhage of brain Duration

Due to..... 195 E

Due to..... 41

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Unknown

(b) Date of occurrence. 2-7-41

(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? Injury at the hands of parties unknown (Specify type of place) (e) Means of injury.....

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

Address..... Date signed.....

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

S-5728