

FILLED OCT 22 1941  
197

5276 A

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

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

Registrar's No. **47**

## 1. PLACE OF DEATH:

(a) County **Clay**

(b) City or town **North Kansas City, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**Crown Drug Store /**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 months**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Nettie R. Sloan Johnson**3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**4. Sex **female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**6. (b) Name of husband or wife **Phillip T. Johnson** 6. (c) Age of husband or wife if alive **80** years7. Birth date of deceased **unknown**  
(Month) (Day) (Year)8. AGE: Years **unknown** Months Days If less than one day  
hr. min.9. Birthplace **Atlanta, Georgia** 1  
(City, town, or county) (State or foreign country)10. Usual occupation **housewife**

11. Industry or business.

12. Name **William A. Hopkins**13. Birthplace **unknown** 9  
(City, town, or county) (State or foreign country)14. Maiden name **Elizabeth Mc Clain** 415. Birthplace **unknown** 4  
(City, town, or county) (State or foreign country)16. (a) Informant **Harold Hopkins**(b) Address **Polo, Missouri**17. (a) **Removal** (b) Date thereof **10-3-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Liberty, Mo.**18. (a) Signature of funeral director **Church - Archer**(b) Address **Liberty, Mo.**19. (a) **10-3-1941** (b) **John A. Weston**  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clay**

(c) City or town **Liberty,** 24  
(If outside city or town limits, write "RURAL")

(d) Street No. **409 N. Leonard** ✓  
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)

If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **3**  
year **1941** hour **1:45** minute **P.** M.21. I hereby certify that I attended the deceased from  
**C O R O N E R** 19

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19

and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** DurationDue to **Coronary Occlusion**Due to **Coronary Occlusion**Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations **Coronary Occlusion**

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) **Coronary Occlusion**(b) Date of occurrence **October 3, 1941**(c) Where did injury occur? **North Kansas City, Mo.**  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Crown Drug Store, North K. C. Mo.**While at work? (Specify type of place) (e) Means of injury **3**23. Signature **P.W. Prather** (M. D. Prather)Address **Epelau Springs Mo.** Date signed **10-3-41**

OCT 7 1947

RECEIVED  
District Health Officer No. 8,  
District File Number 10-21-47  
Date Filed

**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.....

**Harold L. Posson**

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3605

P. O. Address **North Kansas City**

**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.**

B  
41  
228

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

Registration District No. 197

Primary Registration District No. 5276A

1. PLACE OF DEATH

(a) County Clay  
(b) City or town Marion, Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

Nettie R. S. Johnson

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

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased July 29 - 1868  
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 10 (If less than one day, min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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) Oct 3-1941 (Date received local registrar) (b) John S. Morton (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. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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) \_\_\_\_\_  
(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-31376 1941