

No. 2  
-1-4-41  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34059  
Registrar's No. 3999

**FILED NOV 13 1941**  
Registration District No. 277

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:  
St Marys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 2 weeks  
In this community 29 Years 0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Delbert E. Johnson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 510-05-0441

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife. Gene 6. (c) Age of husband or wife if alive 39 years  
7. Birth date of deceased. Nov 30, 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 10 23 hr. min.

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

10. Usual occupation Structural Steel Worker

11. Industry or business SK. - Structural Steel.

MOTHER FATHER { 12. Name Absalon Johnson  
13. Birthplace Scott Co. Va.  
(City, town, or county) (State or foreign country)  
14. Maiden name Rebecca Taylor  
15. Birthplace Scott Co. Va.  
(City, town, or county) (State or foreign country)

16. (a) Informant H. Henry Johnson  
(b) Address 1504 S. 2nd St. Jackson Mo.

17. (a) Burial (b) Date thereof Oct 25 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Maple Hill Cem.

18. (a) Signature of funeral director Timothy James  
(b) Address 1627 E. 10th

19. (a) 10/27/41 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 048  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4109 Mc Gee  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 23  
year 1941 hour 10:40 minute 40 PM

21. I hereby certify that I attended the deceased from Sept 23 1941 to Oct 23 1941  
that I last saw him alive on Oct 23 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral metastasis  
Due to Generalized melanoma  
subcutaneous.  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations Cerebral exploration for biopsy of small tumor  
Of autopsy Same as above

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) \_\_\_\_\_ (e) Cause of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) M.D.  
Address 3119 S. 2nd St. Date signed 10/25/41

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**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, 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. ....

3999

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

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:  
**St. Mary's 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 **Delbert E. 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..... year.....  
7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER { 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)

(Burial, cremation, or removal)

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

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

(b) Address.....

19. (a) **10/27/41** (b) **M. M. Crowe** (Date received local registrar) (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) If foreign born, how long in U. S. A. ?..... years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **October** day **23**  
year **1941** hour..... minute..... M.

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

**Cerebral metastasis**  
**Generalized melano-sacromatosis**  
Due to **Primary mole on back below left scapula.**  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: **cerebral exploration for biopsy revealed tumor**  
Of operations.....  
Of autopsy..... **same as above**

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).....  
(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) (Specify means of injury)  
23. Signature **[Signature]** (M. D. or other)  
Address **3119 [Address]** Date signed **11/4/41**

SUPPLEMENTAL COPY

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

34059