

3-2
3-40
7-39
K23159

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4043

1. PLACE OF DEATH:

(a) County Miami

(b) City or town Hillsdale Shores

(c) Name of hospital or institution: Summit Lutheran H.C. P.O.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether In this community years, months or days) 3 days

3. (a) PRINT FULL NAME Maud Johnson

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex Female

5. Color or race W

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

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

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Dec 27, 1888
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>NO</u>	<u>2</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Henry M. Culla

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

14. Maiden name Adge Bratton

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

16. (a) Informant Mr. George Johnson

(b) Address Hillsdale Shores

17. (a) Removal (b) Date thereof 10-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paola Cem.

18. (a) Signature of funeral director Wilson Son

(b) Address Paola Shores

19. (a) 10/30/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Miami

(c) City or town Hillsdale 14
(If outside city or town limits, write "RURAL") 0

(d) Street No. R.R.
(If rural, give location)

(e) If foreign born, how long in U. S. A? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29
year 1941 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10-28 to 10-29 41, 19
that I last saw her alive on 10-24 41, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Shock
following reserction of bowel
for Strangulated Hernia
Due to Strangulated Hernia

Due to 20

Other conditions (includes pregnancy within 3 months of death)

Duration 29-hr

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Strangulated gut

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 J. H. Dick (M. D. or other) 41
Address 1028 Rindber Rd. Date signed 10-29

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

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.....

Engine Green....., Registered Apprentice No.
working under my personal supervision.

Signed *Engine Green*.....

Licensed Embalmer No. *Kans. 200*.....

P. O. Address *Topeka, Kans.*.....

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.