

Registration District No. 397

Primary Registration District No. 1002

Registrar's No. ....

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town KANSAS  
(c) Name of hospital or institution:  
324 WABASH  
(d) Length of stay: In hospital or institution.....  
In this community 45 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County JACKSON  
(c) City or town KANSAS CITY MO.  
(d) Street No. 324 WABASH  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country 45 YEARS

3. (a) PRINT FULL NAME LUCILE JOHNSON

3. (b) If veteran, name war..... 3. (c) Social Security No. NONE

4. Sex FEMAL 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased APRIL 12 1870

8. AGE: Years 71 Months 10 Days 10 If less than one day..... hr. min.

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

10. Usual occupation HOME

11. Industry or business.....

MOTHER FATHER { 12. Name FRANKLIN MUZZY  
13. Birthplace MAINE  
14. Maiden name LUCILE LINDSAY  
15. Birthplace MAINE

16. (a) Informant ROBERT JOHNSON  
(b) Address 324 WABASH

17. (a) BURIAL (b) Date thereof MARCH 2 1942

(c) Place: burial or cremation ELMWOOD  
18. (a) Signature of funeral director PASSANTINO BRO'S.

(b) Address KANSAS CITY MO.  
19. (a) 2/1/42 (b) M. M. Crowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 28 year 1942 hour 7 minute 45 M.

21. I hereby certify that I attended the deceased from February 27 to February 27, 1942 that I last saw her alive on Feb. 27 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial degeneration chronic

Due to Hypertension  
arterio sclerosis

Other conditions (include pregnancy within 3 months of death) 93H

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?.....  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury.....

23. Signature A. Scardis (M. D. or other) DO.  
Address 2603 Indep. Ave Date signed 2/28/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.**