

Registration District No. 399

Primary Registration District No. 1002

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:  
 K.C. General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 days  
 (Specify whether  
 In this community 3 months  
 years, months or days)

3. (a) PRINT FULL NAME William H. Johnson  
 3. (b) If veteran, name war No record  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male  
 5. Color or race W  
 6. (a) Single, widowed, married, divorced, Widower  
 6. (b) Name of husband or wife No record  
 6. (c) Age of husband or wife if alive No record years

7. Birth date of deceased Dec. 18th 1879 1865  
 (Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days - If less than one day hr. min.

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

10. Usual occupation None listed

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Hodge Johnson  
 13. Birthplace Scotland  
 (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name No record  
 15. Birthplace No record  
 (City, town, or county) (State or foreign country)

16. (a) Informant Record clerk  
 (b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof 3-9-42  
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director  
 (b) Address  
 (c) Place: burial or cremation

19. (a) 3/5/42 (b) M.M. Crowl  
 (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. Helping Hand Institute  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 18th  
 year 1942 hour 12:00 noon Minute M.

21. I hereby certify that I attended the deceased from 2-11-42, 19, to 2-18-42, 19;  
 that I last saw him alive on 2-18-42, 19;  
 and that death occurred on the date and hour stated above.

Immediate cause of death:  
 Chronic myocarditis with auricular fibrillation and Senile Dementia

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? \_\_\_\_\_

(Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature Drury R. Thore (M. D. or other)  
 Address Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

working under my personal supervision.

Signed

*Wm A. [Signature]*

Licensed Embalmer No. ....

3089

P. O. Address

15 E 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.**