DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
[redacted] 19 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23447

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3069

X29-84

18
3
8

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 516 Cypress Ave. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community 56 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City Mo. 3 8
(If outside city or town limits, write "RURAL")

(d) Street No. 516 Cypress Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Alfred D. JOHNSON.

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife John Elvin Johnson

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

7. Birth date of deceased September (Month) 25th (Day), 1861 (Year)

8. AGE: Years 80 Months 10 Days 17 If less than one day hr. min.

9. Birthplace Clay County (City, town, or county) Missouri. 0 (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Alfred Dale
13. Birthplace (City, town, or county) Kentucky. / (State or foreign country)

MOTHER
14. Maiden name Margaret Hardwick.
15. Birthplace (City, town, or county) Kentucky. / (State or foreign country)

16. (a) Informant Mr. Dale Johnson.
(b) Address 516 Cypress Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/42 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington.

18. (a) Signature of funeral director Mellody-McGilley.
(b) Address K. C. Mo.

19. (a) 8-14-42 (Date received local registrar) (b) M. M. Grower (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12th year 1942 hour 9 minute 50 P.M.

21. I hereby certify that I attended the deceased from Feb 15, 1942, 19 to Aug 11, 1942 that I last saw her alive on Aug 11, 1942, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory failure	
Due to Cerebral hemorrhage	3 wks.
Due to arterial hypertension	?
Other conditions (Include pregnancy within 3 months of death) 83	

Major findings:
Of operations
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)
(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 Dr. C. Edwards (M.D.) Other
Address 2603 Indep. Blvd. Date signed 8-13-42
Kansas City, Mo.

241

(Licensed Embalmer's Statement on Reverse Side)

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23447

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3069

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 56 yrs.

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

3. (a) PRINT FULL NAME: ALFRED D. JOHNSON
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: WIDOWER
6. (b) Name of husband or wife: John Elmer
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) Sept 25 (Day) 1860 (Year)
8. AGE: Years 80 Months 10 Days 17 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
MOTHER 15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 10/2/42 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 12 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw he alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY 12