S. No. 2
M—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5267

Registration District No. FILED MAR 5 1943

Primary Registration District No. 10 0X

Registrar's No. 889

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:
Trinity Lutheran Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community 8 yrs.

2. USUAL RESIDENCE OF DECEASED: 999

(a) State: Kansas (b) County: Wyandotte 14

(c) City or town: Kansas City O
(If outside city or town limits, write "RURAL")

(d) Street No. 1631 South Mill
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME: Frances Mabel Johnson

3. (b) If veteran, name war: no

3. (c) Social Security No. 495-10-4300

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: Arthur Johnson

6. (c) Age of husband or wife if alive: 50 years

7. Birth date of deceased: April (Month) 23 (Day) 1891 (Year)

8. AGE: Years 51 | Months 9 | Days 26 | If less than one day ___ hr. ___ min.

9. Birthplace: Platte City (City, town, or county) Mo. O (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: none

FATHER
12. Name: Robert Bullard
13. Birthplace: unknown (City, town, or county) O (State or foreign country)

MOTHER
14. Maiden name: Sarah Frances Leipard
15. Birthplace: unknown (City, town, or county) Penna. 1 (State or foreign country)

16. (a) Informant: Arthur Johnson
(b) Address: 1631 South Mill K.C.K.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 2-21-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Weston, Mo.

18. (a) Signature of funeral director: Fairweather-Werner
(b) Address: 18th & Washington Blvd. K.C.K.

19. (a) 2/21/43 (Date received local registrar) (b) M. M. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19 year 1943 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from 2/14/43, 19__, to 2/19/43, 19__; that I last saw her alive on 2/18/43, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal Obstruction — Duration 2/14/43

Due to: Adhesions from former op.

Due to: 122.B

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: Intestinal obstruction & gangrene of gut.

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: [illegible] (M.D. or other)
Address: 4401 S. [illegible] K.C.K. Date signed 2/20/43

3601

(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 J. Chuck Werner

Licensed Embalmer No. 2598

P. O. Address 1734 Wash. Blvd Kansas City 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.