V. S. No. 2
0M—9-4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27361

FILED AUG 21 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3456

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

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. TB. Hosp. (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 20 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

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

(d) Street No. 709 Independence (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William Hohnson.

3. (b) If veteran, name war no

3. (c) Social Security No. lost.

4. Sex M

5. Color or race C

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

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 6 (Day) 1907 (Year)

8. AGE: Years 36 Months 4 Days 1 If less than one day hr. min.

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

10. Usual occupation laborer

11. Industry or business common

FATHER
12. Name William Johnson
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Susie Warren
15. Birthplace Parson (City, town, or county) Kansas (State or foreign country)

16. (a) Informant Records K.C. TB. Hosp.

(b) Address K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-43 (Month) (Day) (Year)

(c) Place: burial or cremation Seeds

18. (a) Signature of funeral director W. A. Lohmeyer

(b) Address City Mortician

19. (a) 8-10-43 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7 year 1943 hour 4 39 minute P. M.

21. I hereby certify that I attended the deceased from 6-30-43, 19, to 7-7, 1943 that I last saw him alive on 7-7, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	6 m.
Due to	
Due to 13 b	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy Same

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 Matthew J. Noon (M. D. ~~or other~~)

Address K.C. TB Hosp Date signed 7/9/43

(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 with the above constitutes grounds for revocation of license.)

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