

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 149 Primary Registration District No. 1002 State File No. _____ Registrar's No. 4172

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: General Hospital No. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 15 Days
(Specify whether)
 In this community 10 months
years, months or days

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. 1004 Independence Avenue
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ODDIE JOHNSON

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month 9- day 27
 year 1943 hour 8 minute 30 P.M.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased January 15, 1877
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9-13-43 to 9-27-43, 19____, that I last saw him alive on 9-27-43, 19____, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
66 8 12 _____ hr. _____ min.

Immediate cause of death Adenocarcinoma of stomach

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

Due to Generalized carcinoma tosis

10. Usual occupation Laborer

Due to 46

11. Industry or business _____

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

MOTHER FATHER { 12. Name Unknown

Major findings: Of operations _____

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

Of autopsy _____

14. Maiden name Unknown

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant Record Clerk
 (b) Address General Hospital

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) Burial (b) Date thereof 10-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(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?

18. (a) Signature of funeral director W. A. Johnson
 (b) Address Ch. No. 1

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

19. (a) 10-1-43 (b) P. E. Brown
(Date received from Registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) M. D.
 Address General Hospital No. 2 Date signed 9-28-43

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.....

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.