

FILED SEP 7 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

3485

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:
2813 Madison
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether years, months or days) 2 yrs.

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. 2708 Summit
(If rural, give location)
(e) Citizen of foreign country? 8 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Idella Viola 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

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

7. Birth date of deceased: July 14 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 11 If less than one day hr. min.

9. Birthplace Unionville No. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Self

12. Name Joseph Albert Goddard

13. Birthplace no record Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Salinda Jane Bruce

15. Birthplace no record no record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. H. Todd

(b) Address 2813 Madison

17. (a) Burial (b) Date thereof 8-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Gates H. Home

18. (a) Signature of funeral director Memorial Park Gates H. Home

(b) Address 1901 Olive Blvd.

19. (a) 8-26-44 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25 year 1944 hour - minute - M.

21. I hereby certify that I attended the deceased from August 22 1944 to August 25 1944; that I last saw her alive on August 25 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to myocardial degeneration

Due to

Other conditions (Include pregnancy within 3 months of death) 93 d.

Major findings: Of operations none

Of autopsy none

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?

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

23. Signature Carlund DeShazo M. D. or other D.O.
Address 3739 Main Date signed 8-25-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

18
334

361

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..... *W. E. Ward*.....
Licensed Embalmer No..... *3991*.....
P. O. Address..... *309 E. 67*.....
F. E. No.

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.