

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Prairie, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County Emergency Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 months
(Specify whether years, months or days) 40 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Greenwood
(If outside city or town limits, write "RURAL")
(d) Street No. Gen Del. (town)
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME

Ella Johnson

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Albert Johnson

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Jan 3 1868
(Month) (Day) (Year)

8. AGE:

Years 76 Months 6 Days 28
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Thomas Cleland

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

14. Maiden name Frances Belew

15. Birthplace Clay Co, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Johnson

(b) Address Greenwood Mo

17. (a) Burial (b) Date thereof 8-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Mo

18. (a) Signature of funeral director N O Dangersford

(b) Address Lee's Summit Mo

19. (a) July 31, 1944 (b) F. M. Schuck
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1944 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from May 4 1944 to July 31 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Decedent from malnutrition & lack of fluids
Due to Refusing food & drink

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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?

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

23. Signature F. W. Tuttle (M. D. or other)
Address Blue Springs Mo Date signed 8/1/44

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

Blue Springs Mo.

AUG 29 1944

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 N. B. Langford
Licensed Embalmer No. 3833
P. O. Address Lees Summit

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.