

S. No. 2
OM-2-43
v. 5-17-39
1 X35697

36778

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 4 1944
Registration District No. 177

Primary Registration District No. 1002

Registrar's No. 4644

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. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether)

In this community unk
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL") **8**

(d) Street No. 7707 Indiana
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Johnson

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16
year 1944 hour 4 minute A. M.

4. Sex male 5. Color or race White (a) Single, widow, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased: March 7-1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 13, 1944, to Nov. 16, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral pulmonary tuberculosis far advanced Duration

8. AGE: Years 36 Months 7 Days 9 If less than one day 0 hr. 0 min.

Due to _____

Due to _____

Other conditions 13 1/2
(Include pregnancy within 3 months of death)

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

10. Usual occupation laborer

11. Industry or business none

12. Name Wm T Johnson

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

14. Maiden name Beatrice Johnson

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

Major findings:
Of operations _____

Of autopsy See above

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

16. (a) Informant Record clerk

(b) Address 15 E. Gen. Hosp.

17. (a) burial (b) Date thereof 11-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial

18. (a) Signature of funeral director Wm A Johnson

(b) Address City medicinal

19. (a) 11-18-44 (b) T. E. Brown (D. J.)
(Date received local registrar) (Registrar's signature)

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 injury) _____
(c) Means of injury

23. Signature A. E. Oster (M. D. or D. M. S.) D. M. S.

Address Med. Dir. Gen'l Hosp. Date signed 11-16-44

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.