

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1945
Registration District No. _____

Primary Registration District No. **1002**

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 **1-16-45-1-20-45**
(Specify whether
In this community **4 days**
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. **543 Lydia**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JOHN WALTER JOHNSON**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **496-09-2197**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **20**
year **1945** hour **9:05** minute **a.** M.

4. Sex **male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **widowed**
6. (c) Age of husband or wife if alive **17** years **1878**
7. Birth date of deceased **January 17 1878**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **January 16**, 1945, to **January 20**, 1945, that I last saw him alive on **January 20**, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Encephalopathy**

8. AGE: Years **67** Months **0** Days **3**
If less than one day _____ hr. _____ min.

Due to _____
Due to **87 e³**

9. Birthplace: **Starkville Miss.**
(City, town, or county) (State or foreign country)

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

10. Usual occupation **elevator operator**

Major findings: _____
Of operations: _____

11. Industry or business **Jones Store Co**
12. Name **Washington Johnson**
13. Birthplace **Miss.**
(City, town, or county) (State or foreign country)

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

14. Maiden name **Mary Mitchell**
15. Birthplace **Miss.**
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

16. (a) Informant **Record Clerk**
(b) Address **Gen. Hosp. #2.**
17. (a) **Burial** (b) Date thereof **1-23-45**
(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?
While at work? _____ (Specify type of place)
(e) Means of injury _____

(c) Place: burial or cremation **Woodlawn**
18. (a) Signature of funeral director **Mrs. J. W. Jones**
(b) Address **440 State Ave.**
19. (a) **1-25-45** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

23. Signature **J. C. P. [unclear]** (M. D. or other)
Address **Gen. Hosp. #2-600 E. 22** Date signed **1-23-45**

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..... *Eugene English*

Licensed Embalmer No. *4603*

P. O. Address *440 State Ave N. O. La*

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.