. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8648

FILED MAR 24 1945

Registration District No. 799

Primary Registration District No. 1002

Registrar's No. 1107

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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3-3-45-3-5-45 (Specify whether
In this community 30 yr.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 1713 Olive
(If rural, give location)

(e) Citizen of foreign country? no 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JAMES JOHNSON

3. (b) If veteran, name war no

3. (c) Social Security No. 712-03-6562

4. Sex male 9

5. Color or race Negro

6. (a) Single, widowed, married, divorced married 1

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

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

7. Birth date of deceased March (Month) 5 (Day) 1897 (Year)

8. AGE: Years 48 | Months 0 | Days 0 | If less than one day ___ hr. ___ min.

9. Birthplace Muskogee (City, town, or county) Okla. 1 (State or foreign country)

10. Usual occupation butcher

11. Industry or business CUDAHAYS

FATHER
12. Name James M. Johnson
13. Birthplace (City, town, or county) Okla 1 (State or foreign country)

MOTHER
14. Maiden name Don't know
15. Birthplace (City, town, or county) Okla 1 (State or foreign country)

16. (a) Informant Record Clerk
(b) Address Gen. Hosp. #2.

17. (a) ___ (Burial, cremation, or removal) (b) Date thereof 3-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn KCK

18. (a) Signature of funeral director Glyn J Greenstreet
(b) Address 1819 E. 15 K C Mo

19. (a) 3-9-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
year 1945 hour 10:00 minute a. M.

21. I hereby certify that I attended the deceased from March 3, 1945 to March 5, 1945
that I last saw him alive on March 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pulmonary Edema

Due to [redacted] and cardiac decompensation

Due to 95C 2

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Same as above

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature G. C. [illegible] (M. D. or other)
Address Gen. Hosp #2 - 600 E. 22 Date signed 3-9-45

(Licensed Embalmer's Statement on Reverse Side)

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. G. Elgin

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th

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.