

S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
Bureau of Vital Statistics
FILED APR 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12807
Registrar's No. 1382

Registration District No. 149 Primary Registration District No. 1002

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: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
In this community 31 Years
(Specify whether 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. 2052 West 69th Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mrs. Emma Frances Johnson
3. (b) If veteran, name war No
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 25th day March
year 1945 hour 3 minute 20 A.M.
21. I hereby certify that I attended the deceased from March
1941 to March 23, 1945
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Andrew W. Johnson
6. (c) Age of husband or wife if alive _____ years

Immediate cause of death
Uremia
Arterio-sclerotic nephritis
Due to Generalized arterio-sclerosis } Several
1-2 years } Years
Due to Arterio-sclerotic heart disease
Terminal diabetic nephritis ?
Other conditions _____
(Include pregnancy within 3 months of death)

7. Birth date of deceased March 25 1860
(Month) (Day) (Year)

Duration 5 days
Physician _____
Underline the cause to which death should be charged statistically.

8. AGE: Years 85 Months 0 Days 0
If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____
12. Name Amos B. Tomlinson
13. Birthplace Dont Know
(City, town, or county) (State or foreign country)

14. Maiden name Emaline Upson
15. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rae Swanson
(b) Address 2052 West 69th Street
17. (a) Burial (b) Date thereof 3/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt Moriah

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? _____

18. (a) Signature of funeral director Freeman Mortuary
(b) Address Kansas City, Missouri
19. (a) 3-26-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____
While at work? _____ (c) Means of injury _____
23. Signature Joseph Walker (M. D. or other) MD
Address 836 Prof Bldg Date signed 3/25/45

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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City, Mo.

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.