

LED SEP 20 1945

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: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
In this community 10 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson  
(c) City or town Mission  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2643 Brookridge Drive,  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Harry E. Johnston

3. (b) If veteran, name war no. 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Kathryn Johnston 6. (c) Age of husband or wife if alive unknown years  
7. Birth date of deceased March 1 1896  
(Month) (Day) (Year)

8. AGE: Years 49 Months 6 Days 0 If less than one day  
br. min.

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

10. Usual occupation Automobile Executive

11. Industry or business automobile

MOTHER FATHER { 12. Name Thomas E. Johnston,  
13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown,  
15. Birthplace unknown,  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Kathrynne Johnston  
(b) Address 2643 Brookridge Dr., Mission, Kas

17. (a) Burial (b) Date thereof 9-4-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int maiah  
18. (a) Signature of funeral director Stine & McClure,  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 9-4-45 (b) Geraldine Holman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 1st  
year 1945 hour 8:04 minute A. M.

21. I hereby certify that I attended the deceased from August 22, 1945 to Sept 1, 1945  
that I last saw him alive on Aug 31, 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death MI

Duration 27/45

Due to \_\_\_\_\_  
Due to 12:2

Other conditions (Include pregnancy within 3 months of death)

Major findings: Apparent 9/13/45 PHYSICIAN  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) X  
(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) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other)  
Address [Address] Date signed 9/1/45

1961 9 26 MAR

Dr. L. G. Willits

JUL 29 1947

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 E. M. Ploucky

Licensed Embalmer No. 1848

P. O. Address K.C. 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.