

FILED MAY 16 1946

Primary Registration District No. 1002

Registrar's No. _____

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. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hrs.
(Specify whether years, months or days)

In this community 3 yrs - 27 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")

(d) Street No. 2420 1/2 Bales 8
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Christine Johnson

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1946 hour 11 minute P. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar-23-1943
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 20, 1946 to April 20, 1946

that I last saw h. em alive on 4-20, 1946

and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

3	0	27	
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hr. min.

Immediate cause of death non epidemic Encephalitis complicating measles

Duration _____

9. Birthplace K.C. Mo!
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation Child

Other conditions (Include pregnancy within 3 months of death) 35

11. Industry or business _____

12. Name Dr. Johnson

13. Birthplace Norway 4
(City, town, or county) (State or foreign country)

14. Maiden name Rosa Husten

15. Birthplace Missouri
(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 Rosa K. Johnson

(b) Address 2420 1/2 Bales

17. (c) Burial (b) Date thereof Apr-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Warrington

18. (a) Signature of funeral director Wm. C. K. Foster

(b) Address 918 Brooklyn

19. (a) 4-22-46 (b) Theralline Holmes
(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? _____

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

23. Signature Wm. W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 4-22-46

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

MOTHER FATHER

Dr. Buckner

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 *me*

....., Registered Apprentice No.
working under my personal supervision.

Signed *Wm K Jackson*

Licensed Embalmer No. *3954*

P. O. Address *PC 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.