

S. No. 2
M-5-43
y. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13196

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1719

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 8 days
(Specify whether years, months or days)

In this community 50 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. 4103 Penn
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country X

3. (a) PRINT FULL NAME Charles Allen Johnston

3. (b) If veteran, name war NO.

3. (c) Social Security No. 486-03-4948

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Gertrude Johnston

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

7. Birth date of deceased November 17 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>4</u>	<u>18</u>	<u>3</u> hr. <u>3</u> min.

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

10. Usual occupation Retired

11. Industry or business X

MOTHER FATHER

12. Name James E. Johnston

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

14. Maiden name Emma Raples

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frances Elridge

(b) Address 218 Cherokee St., Knoxville, Tenn.

17. (a) burial (b) Date thereof 4-12-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 4-11-46 (b) Thelma Holmea
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1946 hour 4 minute 50 A. M.

21. I hereby certify that I attended the deceased from April 2, 1946, to April 10, 1946,
that I last saw him alive on April 10, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death Empyema (left) following bronchial pneumonia-Acute cardiac dilatation

Due to _____

Due to _____

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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) Med. Dir. Gen'l Hosp.
Address Med. Dir. Gen'l Hosp. Date signed 4-10-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Dr. J. J. ...

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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address 15 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.