

No. 2
4-5-43
5-17-39
1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16713
2145

State File No.

Registrar's No.

Registration District No. 197

Primary Registration District No. 1002

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 19 days
(Specify whether
In this community 20 years
years, months or 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. 1813 Bellview 8
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Omar Johnson

(b) If veteran, name war No

(c) Social Security No. 496-05-4171

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12, year 1946 hour 10: minute 00 A. M.
21. I hereby certify that I attended the deceased from March 23, 19 46, May 12, 1946.

that I last saw him alive on May 12, 1946, and that death occurred on the date and hour stated above.
Immediate cause of death Syphilitic Lepto-meningitis (Chronic)

Duration

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?

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

23. Signature S. D. Yank (M. D. or other) MD
Address General Hospital No. 2 Date signed 5/13/46

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced. Widowed

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

7. Birth date of deceased November 30 1886 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 5 12 hr. min.

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

10. Usual occupation None

11. Industry or business.....

MOTHER FATHER

12. Name William Johnson

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

14. Maiden name Lottie

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

16. (a) Informant Medical Records Librarian

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 5/15/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director W. H. Biss

(b) Address 1729 Lydia

19. (a) 5-13-46 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

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

1000

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..... *J. Jerome Manlove*
Licensed Embalmer No. *3994*
P. O. Address *2503 Highland*

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.