

V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 9 1947

Registrar's No. 2372

Registration District No. 187

Primary Registration District No. 1001

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether years, months or days)

In this community 25 Yrs.
(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. 548 Main
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frank E. Johnson

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased Jan. 13 1899
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
year 1947 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 19, 1947 to May 28, 1947
that I last saw him alive on May 28, 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>4</u>	<u>15</u>	hr. min.

Immediate cause of death Far advanced pulmonary tuberculosis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name W^m Johnson

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

14. Maiden name Lizzie McCrary

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

16. (a) Informant Record Clerk
(b) Address K.C. General Hosp.

17. (a) Burial (b) Date thereof 5-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Milan, Mo.

18. (a) Signature of funeral director Weiler + Funeral Home
(b) Address K.C. Mo.

19. (a) 5-30-47 (b) Thelma Holmes
(Date received local registrar) (Registrar's signature)

Major findings: Of operations 1315

Of autopsy None

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? 0

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

23. Signature W. W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 5-28-47

R. Schuyler

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..... *Blaine E. Wadcut*

Licensed Embalmer No. *4075*

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.