

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36643**
Registrar's No. **4232**

Registration District No. **199**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **JACKSON**
(b) City or town **KANSAS CITY, MISSOURI**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
GENERAL HOSPITAL #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **21 days**
(Specify whether
In this community **UNKNOWN**
years, months or days)

3. (a) PRINT FULL NAME **ALVIN JOHNSON**
3. (b) If veteran, name war **World War I**
3. (c) Social Security No. **493-14-9731**

4. Sex **MALE** 2 5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **UNKNOWN**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **OCTOBER 12th, 1894**
(Month) (Day) (Year)

8. AGE: Years **54** Months **0** Days **10**
If less than one day _____ hr. _____ min.

9. Birthplace **MONROE, LOUISIANA**
(City, town, or county) (State or foreign country)

10. Usual occupation **DAY LABORER**

11. Industry or business _____

12. Name **JAMES JOHNSON**

13. Birthplace **LITTLE ROCK, ARKANSAS**
(City, town, or county) (State or foreign country)

14. Maiden name **IDA BROWN**

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

16. (a) Informant **Brother: ELIJAH JOHNSON**
(b) Address **2611 Tracy**

17. (a) **Burial** (b) Date thereof **10/19/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetary**

18. (a) Signature of funeral director **Walter D. Ellis**
(b) Address **1729 1/2 1st St. S.E.**

19. (a) **10-18-48** (b) **W. Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

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. **1226 TROOST**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCTOBER** day **12th**
year **1948** hour **1:00** minute **P.** M.

21. I hereby certify that I attended the deceased from
September 21, 1948 to October 12th, 1948
that I last saw him alive on **October 12th, 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death
RESPIRATORY FAILURE
Due to **INTRA-CRANIAL NEOPLASMS**
(ETIOLOGY UNDETERMINED (X-RAY EVIDENCE ONLY))
Due to **DENCE ONLY (m. m. a.)**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations **572**
Of autopsy _____

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)
Means of injury **E. Frank Ellis**
23. Signature **Walter D. Ellis** (M. D. or other)
Address **1729 1/2 1st St. S.E.** Date signed _____

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.