

Registration District No. **149**

Primary Registration District No. **1002**

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:
235 Ward Parkway Locarno Apt's.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **X**
60 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mr. Fred M. Johnson**
3. (b) If veteran, **X** **3. (c) Social Security No.** **NO**
 name war

4. Sex **M** **5. Color or race** **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Gertrude A. Johnson**
6. (c) Age of husband or wife if alive. **unk.** years
7. Birth date of deceased. **May 23, 1873**
(Month) (Day) (Year)

8. AGE: Years **75** Months **7** Days **1** If less than one day
 hr. _____ min.

9. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
10. Usual occupation **Mdse. Broker**

11. Industry or business
12. Name **John Johnson**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Fred M. Johnson**
(b) Address **235 Ward Parkway Apt. # 407**
17. (a) Burial **(b) Date thereof** **12-28-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Washington**

18. (a) Signature of funeral director **STINE & McCLURE**
(b) Address **3235 GILLHAM PLAZA K.C., MO.**
19. (a) 12-28-48 (b) Geraldine Holman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **235 Ward Parkway**
(If rural, give location)
 (e) Citizen of foreign country? **X** **NO** (Yes or No)
 If yes, name country **X**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12** day **24**
 year **1948** hour _____ minute _____ P. M.
21. I hereby certify that I attended the deceased from **Oct 24**
 _____, 19____ to **12-24**, 19____
 that I last saw him alive on **12-24**, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chr. Myocarditis**
Duration **Months**
 Due to _____
 Due to _____

Other conditions **Multiple Myeloma of Bone**
(Include conditions which may have contributed to death)
Physician **Dr. [Signature]**
Of autopsy **932**
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. V. Bell**
(M. D. or other)
Address **3235 Gillham Plaza**
Date signed **12-27-48**

Dr. J. D. Bell
411 - Glenview Rd.
Wm. 4350 P.M.

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 Max E. Myers
Licensed Embalmer No. 4555
P. O. Address Kansas City, 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.