

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37334**
4889

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 65yrs		d. STREET ADDRESS (If rural, give location) 2733 Myrtle	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) W. c. (Last) Johnson			4. DATE OF DEATH (Month) (Day) (Year) Nov 15 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH June 6 1875			9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY American Exp. Acy.		11. BIRTHPLACE (State or foreign country) Merriam Kansas	
12. CITIZEN OF WHAT COUNTRY? US.					

13a. FATHER'S NAME August Johnson		13b. MOTHER'S MAIDEN NAME Minnie Emanuelson		14. NAME OF HUSBAND OR WIFE Deceased	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. --		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Selma Cross - 2733 Myrtle	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		DUPLICATE (b) hypertension			5 hours
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **11-15**, 19**49**, to **11-15**, 19**49**, that I last saw the deceased alive on **11-15**, 19**49**, and that death occurred at **10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Jack M. Davis (Degree or title) M.D.		23b. ADDRESS Raytown, Mo		23c. DATE SIGNED 11-17-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 18, 49		24c. NAME OF CEMETERY OR CREMATORY Mt Moriah Cem.	
				24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	

DATE REC'D BY LOCAL REG. 11-17-49		REGISTRAR'S SIGNATURE Steldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gates Funeral Home, K. C. Kans.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Jack Davis
Fl 1104

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.....

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

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.