

FILED DEC 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37337

State File No.

4904

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4904

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| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u> | c. LENGTH OF STAY (in this place) township) <u>53 yrs.</u> | c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3828 Michigan Avenue</u> | | d. STREET ADDRESS (If rural, give location) <u>3828 Michigan Avenue</u> | |

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|---|-----------------------|--------------------------|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u> | b. (Middle) <u>H.</u> | c. (Last) <u>JOHNSON</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 17, 1949</u> |
|---|-----------------------|--------------------------|---|

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|--------------------|-------------------------------|---|---------------------------------|---|--------------------------------|--------------------------------|
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>8-18-96</u> | 9. AGE (in years last birthday) <u>53</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|--------------------|-------------------------------|---|---------------------------------|---|--------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Representative</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maloney Elec. Co.</u> | 11. BIRTHPLACE (State or foreign country) <u>Kansas City, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13a. FATHER'S NAME <u>Joseph M. Johnson</u> | 13b. MOTHER'S MAIDEN NAME <u>Anna M. ----</u> | 14. NAME OF HUSBAND OR WIFE <u>Edith A. Johnson</u> |
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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) <u>Yes WW-I</u> | 16. SOCIAL SECURITY NO. <u>---</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Edith A. Johnson, 3828 Michigan, KC, Mo.</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Kaemonhage of Esophagus Varice</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cirrhosis of Liver</u> | | | <u>2 + 1/2</u> |
| | DUE TO (c) <u>Chronic Alcoholism</u> | | | <u>5 + 1/2</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>(Malnutrition)</u> | | | | |

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|------------------------|--|-------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>None</u> | <u>5811</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|-------------|---|

| | | |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u> | 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 Aug, 1949 to Nov 17, 1949 that I last saw the deceased alive on Nov 16, 1949, and that death occurred at 6:20 pm., from the causes and on the date stated above.

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| 23a. SIGNATURE (Death certificate) <u>Robt. J. Boddy</u> | 23b. ADDRESS <u>217 Plaza Pine Bluff, Mo</u> | 23c. DATE SIGNED <u>11/18/49</u> |
|--|--|----------------------------------|

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|--|---------------------------|--|--|
| 24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>11-19-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Mount Moriah</u> | 24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u> |
|--|---------------------------|--|--|

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|---|---|---|
| DATE REC'D BY LOCAL REG <u>11-18-49</u> | REGISTRAR'S SIGNATURE <u>Heraldine Holmes</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Melody-McGilley-Eylar, Kansas City, Mo.</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 9 1930

Dr. P. B. Brody
1 to 7⁰⁰ PM
411 Alameda Rd.

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 Max W. Kirkendall

Licensed Embalmer No. 4632

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.