

FILED MAR 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 8772  
1061

|  |  |  |   |  |  |   |                                       |   |                               |                               |
|--|--|--|---|--|--|---|---------------------------------------|---|-------------------------------|-------------------------------|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>149</u>  |   | PRIMARY REG. DIST. NO. <u>1002</u>   |  | Registrar's No. _____   |                                       |   |                               |                               |
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Jackson</u>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE<br><u>Mo</u> |  |   |                                       | b. COUNTY<br><u>Jackson</u>   |                               |                               |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <u>Kansas City</u>  |  |  |   | c. LENGTH OF STAY (in this place)<br><u>40 YRS.</u>  |  |   |                                       | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <u>Kansas City</u> |                               |                               |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Robt East 51st St. Sr.</u>   |  |  |   | d. STREET ADDRESS<br><u>2733 Troost Apt. 2</u>   |  |   |                                       | <u>3428</u>   |                               |                               |
| 3. NAME OF DECEASED<br>(Type or Print)   |  |  | a. (First)<br><u>Robert E. Johnson Sr.</u>            |  | b. (Middle)  |   | c. (Last)                             |   |                               |                               |
|  |  |  |   |  | 4. DATE OF DEATH   |   | (Month) (Day) (Year)<br><u>3-5-50</u> |   |                               |                               |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>White</u>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>                                       |  | 8. DATE OF BIRTH<br><u>11-2-1902</u>  |                                       | 9. AGE (in years last birthday)<br><u>48 4/7</u>  |                               |                               |
|  |  |  |   |  |  | IF UNDER 1 YEAR<br>Months Days  |                                       | IF UNDER 24 HRS.<br>Hours Min.  |                               |                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Tavern Owner</u>   |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Tavern</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Sedalia Mo U</u>                |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |                               |                               |
| 13a. FATHER'S NAME<br><u>Adolph Johnson</u>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Margaret B. Stahl</u> |  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Ethel G. Johnson</u>                          |                                       |   |                               |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  |  | 16. SOCIAL SECURITY NO.<br><u>489-22-9607</u>         |  | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Ethel G. Johnson</u> |   |                                       |   | ADDRESS<br><u>2733 TROOST</u> |                               |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION  |   |  |  |   |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u>  |                               |                               |
|  |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis, acute</u>   |   |  |  |   |                                       |   |                               |                               |
|  |  | ANTECEDENT CAUSES  |   |  |  |   |                                       |   |                               |                               |
|  |  | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Coronary Insufficiency &amp; angina pectoris</u> |   |  |  |   |                                       | <u>4-5 hrs.</u>   |                               |                               |
|  |  | DUE TO (c)   |   |  |  |   |                                       |   |                               |                               |
|  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                |   |  |  |   |                                       |   |                               |                               |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION<br><u>4201</u>  |   |  |  |   |                                       | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |                               |                               |
| 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 <u>20 Feb.</u> , 19 <u>50</u> , to <u>27 Feb.</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>27 Feb.</u> , 19 <u>50</u> , and that death occurred at _____ m., from the causes and on the date stated above. |  |  |   |  |  |   |                                       |   |                               |                               |
| 23a. SIGNATURE<br><u>Fred H. Lundgren Jr. M.D.</u>   |  |  |   | 23b. ADDRESS<br><u>67 Professional Bldg.</u>   |  |   |                                       | 23c. DATE SIGNED<br><u>3/6/50</u>   |                               |                               |
| 23d. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23e. DATE<br><u>3-9-50</u>   |   | 23f. NAME OF CEMETERY OR CREMATORY<br><u>Forest Hill</u>   |  | 23g. LOCATION (City, town, or county) (State)<br><u>70 &amp; Troost K.C. MO</u> |                                       |   |                               |                               |
| DATE REC'D BY LOCAL REG.<br><u>3-7-50</u>  |  | REGISTRAR'S SIGNATURE<br><u>Heraldine Holmes</u>   |   |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Thos. E. Quirk</u>    |   |                                       |   |                               | ADDRESS<br><u>4316 Troost</u> |

(Licensed Embalmer's Statement on Reverse Side)

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

**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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_  
Signed *Donald L. Linn*  
Licensed Embalmer No. *3775*  
P. O. Address *2 E 7th*

**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.