

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16804**
2352

FILED JUN 10 1950

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. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		b. COUNTY JACKSON	
c. LENGTH OF STAY (In this place) 15 yrs		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 1716 Benton Blvd.	

3. NAME OF DECEASED (Type or Print) MARGARET	a. (First)	b. (Middle)	c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) MAY 24 1950
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5. SEX FEMALE 3	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE 1	8. DATE OF BIRTH NOT KNOWN	9. AGE (In years) (Month) (Day) (Year) OVER 65	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) LOUISVILLE, KENTUCKY	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME GEORGE JOHNSON	13b. MOTHER'S MAIDEN NAME CORDELIA -	14. NAME OF HUSBAND OR WIFE Unknown
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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. No	17. INFORMANT'S SIGNATURE OR NAME J. B. LAPSLEY K. C. Club	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 44 3/4
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC FAILURE		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE HEART DISEASE WITH DECOMPENSATION DUE TO (c)		
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	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)
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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?
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22. I hereby certify that I attended the deceased from 5-23- 19 50, to 5-24- 19 50, that I last saw the deceased alive on 5-24- 19 50 and that death occurred at 4:30A m., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis MD.	23b. ADDRESS 600 East 22nd Street.	23c. DATE SIGNED 5-24-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/25/50	24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 5-25-50	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Watkins & Sons	ADDRESS 1729 Lydia
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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 Embalmer No.....

Signed.....

J. Jerome Malone

Signed.....

Student Embalmer

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.