No. 300
10-48

FILED MAR 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8572

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 867

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
c. LENGTH OF STAY (in this place) —
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1106 Indep. Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
d. STREET ADDRESS (If rural, give location) 1106 Indep. Ave.

3038

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) c. (Last) Johnson

4. DATE OF DEATH (Month) Feb. (Day) 20, (Year) 1951

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 3-6-1891
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Taylor, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Geo. W. Johnson
13b. MOTHER'S MAIDEN NAME Matilda Cutburth
14. NAME OF HUSBAND OR WIFE Martha Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Spanish-American
16. SOCIAL SECURITY NO. ?
17. INFORMANT'S SIGNATURE OR NAME Coroners Office ADDRESS K.C. Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arterio Sclerosis

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

4221

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. History Heart Gen Hosp

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Post Refused
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Natural
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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Hugh H. Owens (Degree or title) Hugh H. Owens Coroner
23b. ADDRESS 1034 Rialto Bldg
23c. DATE SIGNED 2-21-51

24a. BURIAL CREMATION REMOVAL (Specify) Burial
24b. DATE 2-22-51
24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary
24d. LOCATION (City, town, or county) (State) K.C.K.

DATE REC'D BY LOCAL REG. 2-26-51
REGISTRAR'S SIGNATURE Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE Paul B. Logeltum ADDRESS K.C. Mo.

(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 Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4273

P. O. Address K-C, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.