

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41668

State File No. ....

5294

FILED DEC 26 1951  
BIRTH NO. 76593-57 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. ....

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Shawnee</u>   |  |
| c. LENGTH OF STAY (In this place) <u>6 days</u>   |  | d. STREET ADDRESS (If rural, give location) <u>11500 West 68 Street</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Luke's Hospital</u> |  |   |  |

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|--|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Wendy</u> b. (Middle) <u>Marie</u> c. (Last) <u>Johnson</u> |  |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>11 - 4 - 1951</u> |   |  |
| 5. SEX <u>female</u>   |  | 6. COLOR OR RACE <u>white</u>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u> |  |
| 8. DATE OF BIRTH <u>10-29-51</u>   |  | 9. AGE (In years last birthday) <u>6</u>  |  | IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u>                               |  |
| IF UNDER 1 YEAR Hours <u>0</u> Mins. <u>0</u>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Missouri</u>  |  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                 |   |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 13a. FATHER'S NAME <u>Robert William Johnson</u>                            |  | 13b. MOTHER'S MAIDEN NAME <u>Janet Louise Renne</u> |  | 14. NAME OF HUSBAND OR WIFE   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> |  | 16. SOCIAL SECURITY NO.                             |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. R. W. Johnson</u> ADDRESS <u>11500 W. 68 Shawnee, Kans.</u> |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u><br><br>ANTECEDENT CAUSES<br><u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u><br>DUE TO (b) <u>Intestinal obstruction due to Congenital atresia of small intestine</u><br><br>DUE TO (c)<br><br>II. OTHER SIGNIFICANT CONDITIONS<br><u>Conditions contributing to the death but not related to the disease or condition causing death.</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><u>75 1/2</u> |  |
|--|--|---|--|---|--|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION <u>11/2/51</u>           |  | 19b. MAJOR FINDINGS OF OPERATION <u>Removal of about 8" of small intestine (Congenital atresia)</u>    |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" 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) |  | 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 10-29, 1951, to 11-4, 1951, that I last saw the deceased alive on 11-4, 1951, and that death occurred at 1:45 P.m., from the causes and on the date stated above.

|   |  |  |  |                                  |  |
|---|--|--|--|----------------------------------|--|
| 23a. SIGNATURE <u>Robert C. Fredson</u> (Degree or title) <u>MD</u> |  | 23b. ADDRESS <u>411 Nichols Rd KC 2 Mo</u> |  | 23c. DATE SIGNED <u>11-30-51</u> |  |
|---|--|--|--|----------------------------------|--|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>                                |  | 24b. DATE <u>11-5-51</u>                      |  | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Hospital</u> |  |
| 24d. LOCATION (City, town, or county) (State) <u>St. Luke's Hospital, Kansas City, Mo</u> |  | 24e. DATE REC'D BY LOCAL REG. <u>12-10-51</u> |  | 24f. REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>           |  |
| 24g. FUNERAL DIRECTOR'S SIGNATURE <u>St. Luke's Hospital</u>                              |  | 24h. ADDRESS <u>Kansas City, Mo</u>           |  |   |  |

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

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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.....

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.