

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED AUG 27 1953

State File No. **28699**
3966

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

I. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
a. COUNTY Jackson		b. STATE Missouri c. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 28 yrs.		d. STREET ADDRESS (If rural, give location) 4005 Harrison	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4005 Harrison		e. STREET ADDRESS (If rural, give location) 4005 Harrison	

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) ROBERT	b. (Middle) PAUL	c. (Last) JOHNSON	(Month) AUG.	(Day) 8	(Year) 1953

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH June 17-1876	9. AGE (In years last birthday) 77	10. UNDER 1 YEAR (Months) -	11. UNDER 1 YEAR (Days) -	12. UNDER 1 YEAR (Hours) -	13. UNDER 1 YEAR (Mins.) -
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and State or Foreign Country) Leidsborg Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Daniel Johnson	13b. MOTHER'S MAIDEN NAME Anna Nelson	13c. NAME OF HUSBAND OR WIFE Annabelle Johnson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 487-05-7852	17. INFORMANT'S SIGNATURE OR NAME D. Paul C. Johnson	ADDRESS K.C. Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 410X YEARS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTERIOR MYOCARDIAL INFARCTION.		
	ANTECEDENT CAUSES II. OTHER SIGNIFICANT CONDITIONS RHEUMATIC HEART DISEASE (MITRAL + TRICUSPID VALVES)		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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 April, 1953 to Aug 8, 1953, that I last saw the deceased alive on Aug 6, 1953, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE T. Reid Jones	23b. ADDRESS 1107 Bryan bldg	23c. DATE SIGNED 8-9-53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Aug 11-1953	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, or county) (State) K.C. Missouri
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DATE REC'D BY LOCAL REG. 8-9-53	REGISTRAR'S SIGNATURE Sheldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE C.H. Blackburn & Son Inc.	ADDRESS 15. D. mo
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK

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

W.C. Rine

Licensed Embalmer No. 4879

P. O. Address N.C., 7th

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

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