

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33307**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4316</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death) a. STATE <u>Kansas City</u> b. COUNTY <u>Wyandotte</u> (Division)			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (in this place) <u>6 hrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lakeside Hospital</u>				STREET ADDRESS (If rural, give location) <u>2409 West 47th Terrace</u> S 15 S			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mrs. Agda</u> b. (Middle) <u>Eleanor</u> c. (Last) <u>Johnson</u>			4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>7</u> (Year) <u>1955</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>April 5, 1889</u>	
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Olson</u>			13b. MOTHER'S MAIDEN NAME <u>Matilda Olson</u>		14. NAME OF HUSBAND OR WIFE <u>August Johnson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>August E. Johnson</u> ADDRESS <u>Kansas City, Ks.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Hypertension</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>					331X
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) _____ m.		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 _____, 19 <u>33</u> to <u>10/7</u> , 19 <u>55</u> that I last saw the deceased alive on <u>10/7</u> , 19 <u>55</u> , and that death occurred at <u>6:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Charles Alhante, D.O.</u>				23b. ADDRESS <u>3 EAST 39th St. K.C. Mo.</u>		23c. DATE SIGNED <u>10/8/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 11, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-8-55</u>		REGISTRAR'S SIGNATURE <u>new minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gates Funeral Home, Kansas City, Kans</u> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Chas. A. Kante
3 East 39th
Va- 1800

7-10-23

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.....
Signature of Student Embalmer

Signed..... *Mary L. Gates*

Licensed Embalmer No. *24*

P. O. Address *Kansas City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.