

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33312**

FILED OCT 25 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1022 Registrar's No. 4289

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). - a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	c. LENGTH OF STAY in this place <u>47 yrs</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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Queen of the World</u>		e. STREET ADDRESS (If rural, give location) <u>2635 Vine St.</u>	<u>34180</u>

3. NAME OF DECEASED (Type or Print) a. (First) <u>Vernal</u> b. (Middle) <u>Louise</u> c. (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 5, 55</u>
--	--

5. SEX <u>3</u> <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 1 1908</u>	9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. 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>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	---	---	--

13a. FATHER'S NAME <u>Walter G. Shaw</u>	13b. MOTHER'S MAIDEN NAME <u>Ella M. Stratton</u>	14. NAME OF HUSBAND OR WIFE <u>Amos Johnson</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Amos Johnson</u>	ADDRESS <u>2635 Vine St.</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		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/4 hr</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Arrest</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Complete hysterectomy</u> DUE TO (c) <u>fibroid uterus</u>		
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 <u>fibroid uterus</u>	20. AUTOPSY? YES <input 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)	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 Sept 29, 1955, to Oct 5, 1955, that I last saw the deceased alive on Oct 5, 1955, and that death occurred at 9 p m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <u>Marion W. Richardson M.D.</u>	23b. ADDRESS <u>2526 Prospect</u>	23c. DATE SIGNED <u>10-6-55</u>
---	--------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct. 10, 55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Highland Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
--	---------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>10-6-55</u>	REGISTRAR'S SIGNATURE <u>Neve Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Manlove & Williams</u>	ADDRESS <u>1729 Lydia</u>
--	---	---	------------------------------

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Merion W. Richardson, M.D.

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 *Maynard William*
Licensed Embalmer No. *46*

P. O. Address *1729 Lyden*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.