

FILED MAR 7 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5248**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **115**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Independence</b>		c. CITY OR TOWN <b>Independence</b>	d. Is Residence within limits of a city or incorporated town? <b>yes</b> <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>3 days</b>		e. STREET ADDRESS (If rural, give location) <b>823 S. Forest</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sanitarium</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Walter</b> b. (Middle) <b>T.</b> c. (Last) <b>Johnson</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Mar. 1, 1956</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug. 17, 1894</b>		9. AGE (In years last birthday) <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lake City Arsenal</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Ills.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Nels A. Johnson</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah E. Berry</b>	14. NAME OF HUSBAND OR WIFE <b>Gertrude Johnson</b>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Gertrude Johnson</b>	ADDRESS <b>Independence, Mo.</b>
---	---	--	----------------------------------

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Adenocarcinoma of lung pleura.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
	ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>		
	DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>163x</b>	20. AUTOPSY? <b>NO</b>
------------------------	--	------------------------

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 **Feb. 1, 1956**, to **March 1, 1956**, that I last saw the deceased alive on **Feb. 29, 1956**, and that death occurred at **3:12 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert Messer MD</b>	23b. ADDRESS <b>Independence, Mo.</b>	23c. DATE SIGNED <b>3-1-56</b>
--	---------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>3/3/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
---	-------------------------	---	---

DATE REC'D BY LOCAL REG. <b>3-3-56</b>	REGISTRAR'S SIGNATURE <b>James K. ...</b>	354	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Carson</b>	ADDRESS <b>Independence, Mo.</b>
--	---	-----	--	----------------------------------

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

MAR 9 1956

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 *Tom D. Markland*

Licensed Embalmer No...459

P. O. Address *Indep. 7*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.