

FILED APR 5 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9155

1210

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Linn</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>7 Days</u>		c. CITY OR TOWN <u>Mound City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>R.R. #1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Josephine</u> b. (Middle) <u>Carlile</u> c. (Last) <u>Johnson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March, 19, 1956</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>Aug. 24, 1885</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 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</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Thomas Carlile</u>			13b. MOTHER'S MAIDEN NAME <u>Lazene Robinson</u>		14. NAME OF HUSBAND OR WIFE <u>William G. 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 ADDRESS <u>Thayne Johnson, Overland Pk., Kans.</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>Encephalomalacia, left cerebral hemisphere</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Ligature of l. internal carotid artery + abscess</u> DUE TO (c) <u>Rupture of intracranial internal aneurysm</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Malignant Tumor of stomach</u>					INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u> <u>72 hrs</u> <u>7:30X</u>	
19a. DATE OF OPERATION <u>3-16-56</u>	19b. MAJOR FINDINGS OF OPERATION <u>Reptured aneurysm, bifurcation of l. internal carotid A., intracranial</u>					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 <u>3-12-1956</u> to <u>3-19-1956</u> that I last saw the deceased alive on <u>3-19-1956</u> , and that death occurred at <u>8:30 P. m.</u> , from the causes and on the day stated above.							
23a. SIGNATURE <u>Donald F. Coburn</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>411 Nichols Road</u>		23c. DATE SIGNED <u>3-19-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Mar. 19, 56</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Mound City, Kansas.</u>	
DATE REC'D BY LOCAL REG. <u>3-19-56</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gates Funeral Home, K.C. Kansas</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

9561 67 NMPY

fe-1-1643

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 *Joseph M. O'Connell*  
Licensed Embalmer No. *4694*

P. O. Address *K. O. No.*

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.