Health, Welfare Public Service

300
1-56

FILED OCT 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30780
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 4137

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1 — Length of stay in 1b 4 1/4 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City 3118 — Inside Limits Yes X No ☐
d. STREET ADDRESS 709 Washington (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First William Middle E. Last Johnson
4. DATE OF DEATH: Month 9 Day 16 Year 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-14-1892
9. AGE (In years last birthday): 63 — 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): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Jan-Dee-Doling
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 513-14-2061
17. INFORMANT: Bernice M. Johnson — Address: L.A. Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of stomach with metastases
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 15 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Aug. 6, 1956 to Sept. 16, 1956 and last saw him alive on Sept. 16, 1956
Death occurred at 1:50 P. m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: B. I. Burns M.D. (Degree or title)
22b. ADDRESS: 24th & Cherry
22c. DATE SIGNED: 9-17-1956

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-22-56
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county) (State): Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS: Weilert's: 6900 Troost: K.C. Mo.
25. DATE RECD. BY LOCAL REG.: 9-22-56
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B.I. Burns Courtesy call 11-2-56

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was eml

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed B. E. Weilert

Licensed Embalmer No. 407

P. O. Address K.C. 8,

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