

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

811413
57217473
Registral's No. 227

FILED JUN 7 1957

Registration District No. 146 Primary Registration District No. 3026

S. 300
1-57/

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, give TOWNSHIP only) <u>Independence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Independence, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>423 N. Eubank</u>		Length of stay in 1b <u>37 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>423 N. Eubank</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>W.</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 8-1885</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>11</u>
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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>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Dennison - Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Edward M. Ott</u>	13b. MOTHER'S MAIDEN NAME <u>May Schutte</u>	14. NAME OF HUSBAND OR WIFE <u>Herbert J. Johnson</u>
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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 <u>Ethel C. Hess</u> Address <u>Indep. Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Thrombo-cytopenic Purpura</u>		<u>5th 12 days</u>
	DUE TO (c)		

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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>296x</u>
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20c. TIME OF INJURY Hour <u>9:15</u> a.m. <u>PM</u> Month, Day, Year	20d. -INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Independence, Mo</u>	COUNTY	STATE
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21. I attended the deceased from <u>May 12, 1957</u> , to <u>May 24, 1957</u> and last saw <u>her</u> alive on <u>May 24, 1957</u> Death occurred at <u>9:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Quast Grasse, M.D.</u> (Degree or title)	22b. ADDRESS <u>Independence, Mo</u>	22c. DATE SIGNED <u>5/27/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 28-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maind Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Independence Mo</u>
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24. FUNERAL DIRECTOR <u>Poland R. Speaks</u> ADDRESS <u>Indep. Mo 6-28-57</u>	25. DATE RECD. BY LOCAL REG. <u>5-28-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(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 causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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JUN 4 1957

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 *R. Kenneth Patterson*

Licensed Embalmer No. *4697*

P. O. Address *Indep. Mo.*

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.