

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 12 1957

STATE FILE NUMBER

24644

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

3344

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		Length of stay in 1b 12 yrs.	d. STREET ADDRESS (If outside, give location) 2102 E. 11th St.
3. NAME OF DECEASED (Type or print) Roberta Johnson		First Middle Last	4. DATE OF DEATH July 13, 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 11, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 43 yrs.
11. BIRTHPLACE (City and state or country) Ft. Smith, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Otis Washington		13b. MOTHER'S MAIDEN NAME Rosie Williams	14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 515-20-4472	17. INFORMANT Address Ruby Washington--sis.- 2629 Forest
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b): _____ DUE TO (c): _____			4341
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? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
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 COUNTY STATE
21. I attended the deceased from July 10, 1957 P. to July 13, 1957 and last saw her alive on July 13, 1957 Death occurred at 3:20 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. R. Peterson M.D. (Degree or title)		22b. ADDRESS 600 East 22nd Street	22c. DATE SIGNED 7-17-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-17-57	23c. NAME OF CEMETERY OR CREMATORY Lincoln	23d. LOCATION (City, town, or county) (State) Kans. City, Missouri
24. FUNERAL DIRECTOR Watkins Brothers Funeral Hm. 18th & Benton		25. DATE RECD. BY LOCAL REG. 7-17-57	26. REGISTRAR'S SIGNATURE Nora Minchell

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 *Walter Bras. Fa. No.*

Licensed Embalmer No. *4500*

P. O. Address *K. C.*



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.