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FILED AUG 7 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 24940

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 322

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Independence — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 1820 Ralston — Length of stay in Hospital: 47 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Independence 700 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1820 Ralston — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: John Middle: Robert Last: Johnson

4. DATE OF DEATH: Month: July Day: 27 Year: 1957

5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec 1, 1881

9. AGE (In years last birthday): 75 — 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): Ret. Piano Tuner
10b. KIND OF BUSINESS OR INDUSTRY: Music
11. BIRTHPLACE (City and state or country): Sweden
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Peter Johnson
13b. MOTHER'S MAIDEN NAME: Emma
14. NAME OF HUSBAND OR WIFE: Anna Johnson

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.: 499-09-0822A
17. INFORMANT: Anna Johnson Address: 1820 Ralston

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	BRONCHOPNEUMONIA	12 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	PARALYSIS	6 YRS
DUE TO (c)	CEREBRAL HEMORRHAGE	6 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X

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 JAN. 1956, to July 27, 1957 and last saw her/him alive on 7/27/57
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. Richard Ogee MD
22b. ADDRESS: 631 S Noland Independence Mo
22c. DATE SIGNED: 7/29/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-30-57
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
23d. LOCATION (City, town, or county) (State): Indep. Mo

24. FUNERAL DIRECTOR: Dixon L. Kepley ADDRESS: Indep. Mo
25. DATE RECD. BY LOCAL REG.: 7-30-57
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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AUG 5 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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.