

Health,  
Welfare  
Public  
Service

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31955  
STATE FILE NUMBER 3867

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300 4  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Colonial Nursing Home</b>		Length of stay in 1b <b>55 yrs.</b>		d. STREET ADDRESS <b>7209 Washington</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AMANDA JOHNSON</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>15th,</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-13-1878</b>	9. AGE (In years last birthday) <b>79</b>	10. FUNDER 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) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Knoxville, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME <b>Hannah Olson</b>		14. NAME OF HUSBAND OR WIFE <b>Fred Johnson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Edgar H. Finley K. C. Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Arterio Sclerosis</b>		DUE TO (c) <b>Senility</b>		<b>10 yrs - 3 1/2 x</b>	
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 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 <b>June 1, 1953</b> to <b>August 15, 1957</b> and last saw her alive on <b>August 11, 1957</b> . Death occurred at <b>3 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>M. B. Casebolt MD</b> (Degree or title)				22b. ADDRESS <b>4000 Baltimore</b>		22c. DATE SIGNED <b>8/16/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 17, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jackson County, Missouri</b>		
24. FUNERAL DIRECTOR <b>FREEMAN MORTUARY, Kansas City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>8-17-57</b>		26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

M. B. Casebolt



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 *Ray A. Barnes*

Licensed Embalmer No. 4793  
P. O. Address K.C. 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.