

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35918

STATE FILE NUMBER

FILED NOV 5 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4867

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) OR <u>Kansas City</u> TOWN <u> </u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General #2</u>		Length of stay in 1b <u>30 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>1605 E. 14</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>BEN</u> Middle <u> </u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1957</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1887</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Yards</u>	11. BIRTHPLACE (City and state or country) <u>Nacogoches, Texas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Matilda Johnson</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>401-09-9041</u>	17. INFORMANT <u>Matilda Johnson</u>	Address <u>1605 E. 14th</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>Edema of Brain</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypostatic Congestion Left Lung & Acute Pleurisy</u> DUE TO (c) <u>Bilateral diffuse Interstitial Hemorrhage of muscles of skull.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Dont Know</u>
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20c. TIME OF INJURY Hour <u>11:30</u> Month <u>9</u> Day <u>19</u> Year <u>57</u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>1915 Tracy</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City, Jackson Mo</u>	COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Deputy Coroner</u>	22b. ADDRESS <u>1618 Lydia Ave.</u>	22c. DATE SIGNED <u>10/21/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-24-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>K-C. Mo</u>
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24. FUNERAL DIRECTOR <u>Brigham & Jones</u>	ADDRESS <u>18th & Park</u>	25. DATE RECD. BY LOCAL REG. <u>10-21-57</u>	26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

L.M. Tillman

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.

KIP
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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 *Lawrence A. Jones*

Licensed Embalmer No. *4429*

P. O. Address *7300 E. 12*

70027 No

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.