92 381-58

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036443
STATE FILE NUMBER

FILED NOV 14 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5006

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MO. Inside Limits Yes ✓ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LUKE'S Hosp. Length of stay in 1b 21 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY, MO. Inside Limits Yes ✓ No ☐
d. STREET ADDRESS (If outside, give location) 5550 WABASH Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First CHABER Middle Last JOHNSON
4. DATE OF DEATH Month 10 Day 23 Year 58
5. SEX MALE
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH ~~10-28~~ 10-2-58
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 21 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT
10b. KIND OF BUSINESS OR INDUSTRY INFANT
11. BIRTHPLACE (City and state or country) KANSAS CITY, MO.
12. CITIZEN OF WHAT COUNTRY U. S.
13. FATHER'S NAME Charles R. JOHNSON
14. MOTHER'S MAIDEN NAME Birtie Emery
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Chas. Johnson Address 5660 Wabash K.C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PREMATURE BIRTH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ATELECTASIS,
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 21 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 7 lb 25
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2
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 10-2-58 to 10-23-58 and last saw ~~him~~ him alive on 10-23-58
Death occurred at 10:25 p m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Raymond B Anderson (Degree or title) MD
22b. ADDRESS 411 Nichols Rd K.C. Mo
22c. DATE SIGNED 10-24-58
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION
23b. DATE 10-27-58
23c. NAME OF CEMETERY OR CREMATORY Elmwood-Crematory
23d. LOCATION (City, town, or county) (State) K.C. Mo.
24. FUNERAL DIRECTOR Melloy-McGilley-Eylar ADDRESS K.C. Mo
25. DATE RECD. BY LOCAL REG. 10-24-58
26. REGISTRAR'S SIGNATURE Neva Minshall

(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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Raymond B. Anderson

. Health, & Welfare . Public h Service

S. 300
. 1-56

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 50

P. O. Address K.C. M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.