

pt. Health,  
, & Welfare  
S. Public  
Hh Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036447  
STATE FILE NUMBER

FILED NOV 14 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5089

S. 300  
v. 1-57

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>V.A. Hospital</b>		Length of stay in lb <b>41 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>1424 Holmes</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>RUBEN JOHNSON</b>			4. DATE OF DEATH Month <b>10th</b> Day <b>22nd</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-88</b>	9. AGE (In years last birthday) <b>70 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>	11. BIRTHPLACE (City and state or country) <b>Craig County, Okla.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Ruben Johnson,</b>		13b. MOTHER'S MAIDEN NAME <b>Amandy Adair</b>		14. NAME OF HUSBAND OR WIFE <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWT</b>		16. SOCIAL SECURITY NO. <b>187 07 6475</b>		17. INFORMANT Address <b>V.A. Hospital Records, 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>Bronchopneumonia, R. L. &amp; M. L.</b>					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) <b>Bronchial carcinoma, R. L. L.</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? <b>1621</b> YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input checked="" type="checkbox"/> 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>September 26, 1958</b> to <b>October 22, 1958</b> in accordance with the provisions of the law. Death occurred at <b>2:55</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. A. Turner</i> (Degree or title) <b>J. A. TURNER, M. D. MD</b>			22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>		22c. DATE SIGNED <b>10-28-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-29-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or country) (State) <b>Ft. Leavenworth, Kansas</b>
24. FUNERAL DIRECTOR <b>Mrs. Meek's Mortuary K.C.Mo</b>			25. DATE RECD. BY LOCAL REG. <b>10-28-58</b>	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.



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 Millard B Paskein

Licensed Embalmer No. 5013

P. O. Address K C Mo

3-42- 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.