Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005643
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 882

1. PLACE OF DEATH a. COUNTY Jackson	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3421 Garner — Length of stay in 1b 43 yrs.	d. STREET ADDRESS (If outside, give location) 3421 Garner — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First: Dollie	Middle: Frances	Last: Johnson	4. DATE OF DEATH Month Day Year: Feb. 15, 1959	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: Dec. 8, 1902	9. AGE (In years last birthday): 56 — 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): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (City and state or country): Hiawatha, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: Arthur Jackson	13b. MOTHER'S MAIDEN NAME: Ida M. Anderson	14. NAME OF HUSBAND OR WIFE: William W. 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. 496-24-3370	17. INFORMANT Address: William W. Johnson		

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) Death by Hanging

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [X] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Set Arrived hanging in basement - Left note

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 2-15-59

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Residence

20f. CITY, TOWN, OR LOCATION Kans City COUNTY Jackson STATE Mo

21. I attended the deceased from _____, to _____ and last saw he/him alive on _____

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) Hugh H. Owens Coroner	22b. ADDRESS 1034 Rialto Bldg	22c. DATE SIGNED 2-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 17, 1959	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR Stine and McClure — ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 2-16-59	26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

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 ..... Signed William M. Turne
Signature of Student Embalmer

Licensed Embalmer No. 4648
P.O. Address Kansas City

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.