

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005645  
State File No.

FILED FEB 19 1959

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrant No. 578

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY, Mo. 2 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grandview 70%	
d. FULL NAME OF HOSPITAL OR INSTITUTION MEMORAH HOSPITAL		d. STREET ADDRESS (If rural, give location) 12824 Grandview Rd.	

3. NAME OF DECEASED (Type or Print) JENNIE	a. (First) B.	b. (Middle) JOHNSON	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 1-29-59
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APR 22, 1871	9. AGE (In years last birthday) 87	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Liberty, DeWitt, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JACOB E. ARMITAGE	13b. MOTHER'S MAIDEN NAME MARGARET EAGAN	14. NAME OF HUSBAND OR WIFE AMBROSE JOHNSON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY (If yes, give war or dates of service) NO NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. MARTHA A. GILLEN
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 215 E YALE AVE ORLANDO, FLA.		INTERVAL BETWEEN ONSET AND DEATH 2 days
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction	DUE TO (b) Coronary sclerosis		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from December 19 57, to Jan. 29, 19 59, that I last saw the deceased alive on Jan 28, 19 59, and that death occurred at 11:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE Raymond J. Caffrey (Degree or title) MD	23b. ADDRESS Grandview, Mo	23c. DATE SIGNED 1-30-59
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-31-59	24c. NAME OF CEMETERY OR CREMATORY Mt. MORIAN Cemetery	24d. LOCATION (City, town, or county) (State) K.C. Mo.
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DATE REC'D BY LOCAL REG. 1-30-59	REGISTRAR'S SIGNATURE neva minishall	25. FUNERAL DIRECTOR'S SIGNATURE E. Berger, Inc	ADDRESS Dec Grandview Mo.
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(Licensed Embalmer's Statement on Reverse Side)

Raymond J. Caffrey

801-5482

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 .....  
Student Embalmer

Signed *Sterling E. Goddard*

Licensed Embalmer No. 4911

P. O. Address Grandview 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 this body is not embalmed, fact should be so stated above.