

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009482
STATE FILE NUMBER
1216

MAR 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | c. CITY OR TOWN Chillicothe | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Childrens Mercy | | d. STREET ADDRESS (If outside, give location) 4 1/2 Wise St. | |
| Length of stay in lb hrs 7 hrs | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|---------------------------|---|---|--|--------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last Debra Kay Johnson | | | 4. DATE OF DEATH Month Day Year 3-6-59 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-4-59 | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY Child | 11. BIRTHPLACE (City and state or county) Chillicothe Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME William D. Johnson | | 13b. MOTHER'S MAIDEN NAME Mary Nida | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. - | 17. INFORMANT Address William D. Johnson 4 1/2 Wise Chillicothe | | |

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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) Erythroblastosis Fetalis | | 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) _____ | | |
| 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 <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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|---|--|---|
| 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 Month, Day, Year a.m. p.m. | | |
| 20d. INJURY OCCURRED WHILE AT <input 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.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

21. I attended the deceased from 3-5-59 to 3-6-59 and last saw her alive on 3-6-59
Death occurred at 2:50 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | | |
|------------------------------------|-------------------|------------------------------------|----------------------------|
| 22a. SIGNATURE R.D. Patton M.D. | (Degree or title) | 22b. ADDRESS 1710 Endeavor Ave. | 22c. DATE SIGNED 3/6/59 |
|------------------------------------|-------------------|------------------------------------|----------------------------|

| | | | |
|--|---------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 3-6-59 | 23c. NAME OF CEMETERY OR CREMATORY Resthaven | 23d. LOCATION (City, town, or county) (State) Chillicothe Mo. |
|--|---------------------|---|--|

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|---|---------|--|--|
| 24. FUNERAL DIRECTOR Steve + McClure K.C., Mo. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 3-6-59 | 26. REGISTRAR'S SIGNATURE Neva Marshall |
|---|---------|--|--|

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 All diseases in Part I must be causally related.
 R. D. Patton

2)

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 *Joe B. Yoder*

Licensed Embalmer No. *4173*

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.