

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009483

STATE FILE NUMBER

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1233

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		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4532 JEFFERSON		d. STREET ADDRESS (If outside, give location) 4532 JEFFERSON	
3. NAME OF DECEASED (Type or print) First Middle Last Roy Elmore Johnson		4. DATE OF DEATH Month Day Year MAR. 5-1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL-28-1891
9. AGE (In years last birthday) 67		10. KIND OF BUSINESS OR JOHNSON VENETIAN BLIND COMPANY	11. BIRTHPLACE (City and state or country) DELPHOS, KANSAS
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. MOTHER'S MAIDEN NAME AURILLA MOORE	
13a. FATHER'S NAME CARL D. JOHNSON		14. NAME OF HUSBAND OR WIFE MRS. HAZEL N. JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 495-05-5346	
17. INFORMANT Donald N. Johnson		6439 NORWOOD ROAD FAIRWAY, KANSAS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of liver & General peritoneum (Carcinomatosis) DUE TO (b) Adenocarcinoma of Cecum DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 Mos. + 6 Mos. + 1537
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 17 Oct. 1950, to 5 March 59 and last saw him alive on 5 March 1959 Death occurred at 7:55 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Philip G. Kaul M.D.		22b. ADDRESS 411 Nichols Road	
22c. DATE SIGNED 6 March 59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MARCH 7, 1959	
23c. NAME OF CEMETERY MT. MORIAH CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR D.W. NEWCOMERS Sons-KANSAS CITY		25. DATE RECD. BY LOCAL REG. 3-7-59	
26. REGISTRAR'S SIGNATURE Reva Minshall			

(Licensed Embalmers' Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Philip G. Kaul

MEDICAL CERTIFICATION

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 *Vern Lawler*

Licensed Embalmer No. *4915*
P. O. Address *KC 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.