

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009485
STATE FILE NUMBER
1336

FILED MAR 26 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Independence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>V.A. Hospital</u>		Length of stay in lb <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>600 B. Cedar</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Willard</u> Middle <u>M.</u> Last <u>JOHNSON</u>			4. DATE OF DEATH Month <u>3rd</u> Day <u>12th</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-95</u>	9. AGE (In years last birthday) <u>63 yrs</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (City and state or country) <u>Lees Summit, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>N.G. Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Weiss</u>		14. NAME OF HUSBAND OR WIFE <u>Rena Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>487 05 4507</u>	17. INFORMANT Address <u>V. A. Hospital Records, K.C., Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure and shock</u>					<u>3-4 days</u>
DUE TO (c) <u>Old Cor Pulmonale & Pulmonary Hypertension</u>					<u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4344</u>					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.) <u>4344</u>			
20c. TIME OF INJURY Hour <u>VA</u> Month, Day, Year a.m. <u>AT WORK</u> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>March 12 1959</u> to <u>March 12, 1959</u>		Death occurred at <u>4:05p</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Hugh H. Owen</u>		(Degree or title) <u>MD</u>	22b. ADDRESS <u>V.A. Hospital, Kansas City, Mo</u>		22c. DATE SIGNED <u>3-12-59</u>
23a. BURIAL CREMATION, (Specify) <u>Burial</u>		23b. DATE <u>3-16-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Independence, Missouri</u>
24. FUNERAL DIRECTOR <u>Geo. C. Carson & Sons, Indep., Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-13-59</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

Health, Welfare, Public Service
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Hugh H. Owen
All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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 *Dean W. Huff*

Licensed Embalmer No. *4914*

P. O. Address *Indy, 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.