

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-016815

FILED JUN 15 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 599 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in tb <u>1 day</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u> c. CITY OR TOWN <u>Prairie Village</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>7635 Nall Ave.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ranch House Motel</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 3 <u>Belt & Faraon Sts.,</u>			

3. NAME OF DECEASED (Type or print) First <u>Fletcher</u> Middle <u>A.</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>June</u> Day <u>4,</u> Year <u>1959</u>		
---	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/4/1905</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
------------------------------	---	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive Supplier</u>	11. BIRTHPLACE (City and state or country) <u>Lueningburg, Mass.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	--

13a. FATHER'S NAME <u>James M. Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Bernice Agnes Wood</u>	14. NAME OF HUSBAND OR WIFE <u>Claudine Sims 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</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Kansas</u> <u>Mrs. Claudine S. Johnson, Prairie Village.</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>Apparently natural Causes.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Investigated by City Health Dept.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>acute.</u>
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
---	--	---	--	--

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 _____ a.m. _____ p.m. Month, Day, Year _____			
--	--	--	--

20d. INJURY OCCURRED WHILE AT WORK <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 _____ to _____ and last saw her/him alive on _____
 Death occurred at 10:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert W. Keeler, M.D.</u>	22b. ADDRESS <u>St. Joseph, Mo</u>	22c. DATE SIGNED <u>6-6-59</u>
---	---	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>June 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osceola, Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Osceola, Missouri</u>
---	---	---	--

24. FUNERAL DIRECTOR ADDRESS <u>W. Schaffer - Heaman Ave. St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 9, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 15 1959

JUN 23 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eric J. Harvey

Licensed Embalmer No. 4679

P. O. Address St. Joseph, 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.