

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017780

STATE FILE NUMBER 2096

FILED MAY 21 1959

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>Kansas</b><br>b. COUNTY <b>Jackson</b>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Kansas City</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Independence</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Josephs Hosp.</b>  |  | Length of stay in lb<br><b>non Resident</b>   | d. STREET ADDRESS (If outside, give location)<br><b>621 North 9th St.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Arthur R Johnson</b>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>April 26 1959</b>   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4 9 1910</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PAY ROLL CLERK SINCLAIR OIL CO.</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Independence, Mo. IND. KA.</b>  |
| 13a. FATHER'S NAME<br><b>CHARLES A JOHNSON</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>ALDALIDE WILKERSON</b>  | 14. NAME OF HUSBAND OR WIFE<br><b>HILDA</b>  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown. If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>   | 17. INFORMANT<br><b>HILDA JOHNSON Independence, Mo. IND. KA.</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Atherosclerosis</b><br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 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?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour a.m. p.m.  | 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 _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>D. W. Newcomers Sons</b>  | 22b. ADDRESS<br><b>6627 Riverside Ave</b>  | 22c. DATE SIGNED<br><b>4-27-59</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>4 27 59</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. HOPE</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Independence, Kansas.</b>  |
| 24. FUNERAL DIRECTOR<br><b>D. W. Newcomers Sons</b>  | ADDRESS<br><b>Kansas City, Mo.</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>4-27-59</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Neva Marshall</b>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Geo. C. Kealhofer

SEP 28 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 me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Vern Lawler* .....

Licensed Embalmer No. *4918*  
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.