

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021459

FILED JUL 8 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2952 Registrar's No.

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4343 Cypress		Length of stay in hospital LIFETIME	d. STREET ADDRESS (If outside, give location) 4343 Cypress

3. NAME OF DECEASED (Type or print) First Ray Middle Earl Last Johnson			4. DATE OF DEATH Month June Day 17 Year 1959		
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5. SEX D Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 26, 1883	9. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STONE MASON	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) STREETER, ILL.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME JOHN JOHNSON	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE CLARA M. JOHNSON
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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. 496 09 3765	17. INFORMANT MRS. CLARA M. JOHNSON 4343 CYPRESS K. C. MO.	Address
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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) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 4201
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 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.)
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20c. TIME OF INJURY 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
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Merch of Queens Cornea	(Degree or title) 3	22b. ADDRESS 1034 Briarwood Blvd	22c. DATE SIGNED 6-17-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 19, 1959	23c. NAME OF CEMETERY OR CREMATORY WHITE CHAPEL MEMO. GARDENS	23d. LOCATION (City, town, or county) KANSAS CITY, MO.	(State)
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24. FUNERAL DIRECTOR D.W. Newcomers Sons Kansas City, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 6-17-59	26. REGISTRAR'S SIGNATURE new minshall
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

High H. Owens

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 *Raymond M. Hardy*
Licensed Embalmer No. *4913*
P. O. Address *2 day m*

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.