URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 17 1959

59-040141

STATE FILE NUMBER

MENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5218

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 14 weeks
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Trinity Lutheran Hosp.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Johnson
c. CITY OR TOWN Prairie Village
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2311 W. 77nd Terr.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: OLEPHINE Middle: LEE Last: JOHNSON
4. DATE OF DEATH Month: October Day: 29 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 7-23-1879
9. AGE (last birthday): 80
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): At Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Vistarn, Norway
12. CITIZEN OF WHAT COUNTRY: Norway
13a. FATHER'S NAME: Leonard Lee
13b. MOTHER'S MAIDEN NAME: Sarah Ann ---
14. NAME OF HUSBAND OR WIFE: Otto Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Josephine Johnson Address: Prairie Village, Ks.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma G.B.
INTERVAL BETWEEN ONSET AND DEATH: June 5'9
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1947, to 29 Oct 59 and last saw her alive on 29 Oct 59
Death occurred at Trinity Hosp. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert M. Myers M.D.
22b. ADDRESS 1029 Health Bldg.
22c. DATE SIGNED 30 Oct 59

BY AFFIDAVIT OF Robert M. Myers

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 31, 1959
23c. NAME OF CEMETERY OR CREMATORY: Floral Hills
23d. LOCATION (City, town, or county) (State): Kansas City, Missouri
24. FUNERAL DIRECTOR: Freeman Mortuary ADDRESS: Kansas City, Mo.
25. DATE RECD. BY LOCAL REG.: 10-30-59
26. REGISTRAR'S SIGNATURE: Nova Marshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

Dr Robert M. Myers
Rialto Bldg
VT-2-4751
10:30 A.M. Friday

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Clayton Barnes

Licensed Embalmer No. 4793

P. O. Address K. C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.