

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000651

FILED VS JAN 14 1960

Registration District No. 59 Primary Registration District No. \_\_\_\_\_ Registrar's No. 10

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Cass</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Camp Branch Lp.</u>		Length of stay in 1b		c. CITY OR TOWN <u>Harrisonville</u>		Inside Limits <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Vance</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>4</u> Year <u>1960</u>									
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Wh.</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>6-25-1895</u>		9. AGE (last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Boonville, N. Car.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Jim H. Johnson</u>				13b. MOTHER'S MAIDEN NAME <u>Frances Cretcher</u>				14. NAME OF HUSBAND OR WIFE <u>Nora Johnson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Type no, or unknown) (If yes, give war or dates of service) <u>1st. W. War</u>				16. SOCIAL SECURITY NO. <u>490-422629</u>		17. INFORMANT <u>Mrs. Nora Johnson, Harrisonville, 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>CHR MYOCARDITIS*CARDIAC DECOMPENSATION</u>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>PULMONARY OEDEMA</u>													
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. <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 checked="" 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 <u>DEC. 29 1959</u> , to <u>JAN. 4 1960</u> and last saw her/him alive on <u>1/3/60</u> Death occurred at <u>5:20 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>David Shong M.D.</u> (Doctor or title)						22b. ADDRESS <u>HARRISONVILLE, MO.</u>			22c. DATE SIGNED <u>1-7-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-7-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>		23d. LOCATION (City, town, or county) <u>Harrisonville</u>		STATE <u>Mo</u>					
24. FUNERAL DIRECTOR <u>A. D. Hartzler</u> ADDRESS <u>East Lynne, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>1-7-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Roy Sebree</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 2 1980

0981

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_

Signature of Student Embalmer

Signed John R. Sidm  
Licensed Embalmer No. 453  
P. O. Address Kansas City

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