

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JAN 25 1960

=60-001647

210 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1 Hr.		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1735 So. Hardy		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CARL Middle FREDERICK Last JOHNSON				4. DATE OF DEATH Month 1 Day 12 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9 5 1899	9. AGE (last birthday) 60	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) Welder			10b. KIND OF BUSINESS OR INDUSTRY Chev. Plant		11. BIRTHPLACE (City and state or country) South Wayne Wisc.		12. CITIZEN OF WHAT COUNTRY U. S. A		
13a. FATHER'S NAME Martin Johnson			13b. MOTHER'S MAIDEN NAME Marta Andrews			14. NAME OF HUSBAND OR WIFE Ruth I. Johnson			
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. 486 09 1981		17. INFORMANT Address Mrs. Ruth I. Johnson 1735 So. Hardy				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage resulting from fractured skull, fractured skull with brain damage, fractured pelvis, multiple fractures DUE TO (b) multiple fractures DUE TO (c) _____ 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)						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 checked="" type="checkbox"/> NO <input 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.) Fell from ladder							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 1-26-60		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Factory		20f. CITY, TOWN, OR LOCATION Kansas City, Missouri		STATE	
21. I attended the deceased from _____, to _____ and last saw him/her alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Dwight C. Keahof, 2nd Deputy Coroner				22b. ADDRESS 6627 Prospect St. Overland Park, Mo			22c. DATE SIGNED 1-13-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1 15 1960	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) (State) Kansas City, Mo				
24. FUNERAL DIRECTOR ADDRESS Floral Hills Mem. Chapels, Inc				25. DATE RECD. BY LOCAL REG. 1-13-60		26. REGISTRAR'S SIGNATURE Neva Marshall			

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION
Dwight C. Keahof

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 Forrest D. Goldsman

Licensed Embalmer No. 4714

P. O. Address KC 440

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.