

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

149

Registration District No. 1002 Primary Registration District No. 1002

3981

=60-030609

STATE FILE NUMBER

INDEXED

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		Length of stay in 1b 1 day		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION QUEEN OF THE WORLD HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 230 1/2 CAMPBELL		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CAMILLE Middle LOUISE Last JOHNSON				4. DATE OF DEATH Month 7 Day 30 Year 60				
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-29-60	9. AGE (last birthday) 1 day	IF UNDER 1 YEAR Months 13 Days 55	IF UNDER 24 HR Hours 13 Mins 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) KANSAS CITY, MISSOURI		12. CITIZEN OF WHAT COUNTRY USE	
13a. FATHER'S NAME JOSEPH JOHNSON			13b. MOTHER'S MAIDEN NAME OLA MAE SCOTT			14. NAME OF HUSBAND OR WIFE <i>none</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address JOSEPH JOHNSON, father 230 1/2 CAMPBELL KCMO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis of the lungs; generalized visceral congestion DUE TO (b) _____ 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 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 7-29-60 to 7-30-60 and last saw her 2:15 A.M. and last saw him alive on 7-30-60 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) Albert M. Crocker M.D.				22b. ADDRESS E 2024 E. 31st		22c. DATE SIGNED 8/1/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-5-60	23c. NAME OF CEMETERY OR CREMATORY HIGHLAND CEMETERY		23d. LOCATION (City, town, or county) KANSAS CITY, MISSOURI				
24. FUNERAL DIRECTOR WATKINS BROTHERS			ADDRESS 18th & Benton		25. DATE RECD. BY LOCAL REG. 8-3-60	26. REGISTRAR'S SIGNATURE H. L. Sawyer, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Albert M. Crocker**

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEMPHIS, TENNESSEE

MEMPHIS

1-22-60

MISSISSIPPI DEPARTMENT OF HEALTH

Attest: _____
Commissioner

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Bruce R. Watkins

1-22-60

1-22-60

MISSISSIPPI
DEPARTMENT OF HEALTH

Licensed Embalmer No. 4500

P. O. Address New Boston

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.