SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-013039
STATE FILE NUMBER

AMENDED

Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 65

FILED MAY 3 1961

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Rural
Length of stay in 1b: 6 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5825 N. Clements
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 449½ N. Colorado
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MRS. BELLE Middle: TURNER Last: JOHNSON
4. DATE OF DEATH: Month: April Day: 27 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Jan. 4, 1884
9. AGE (last birthday): 77
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): Phillipsburg, Ks.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Fred R. Johnson, dec.
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: Mrs. D. L. Gibson Address: 5825 N. Clements, K. C., Mo.

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): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic-Hypertensive C-V disease — 10+ yrs
DUE TO (c): Congestive Heart Failure — 1+ mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Obesity.
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 5-29-1954 to 4-27-61 and last saw her alive on 4-22-61
Death occurred at 7:30 AM. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: [signature] (Degree or title): MD
22b. ADDRESS: 1530 Paseo Blvd Kansas City, Mo.
22c. DATE SIGNED: 4-27-61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Apr. 29, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rosebank Cemetery
23d. LOCATION (City, town, or county) (State): Mulberry, Kansas
24. FUNERAL DIRECTOR: OTT & MITCHELL, Indep., Mo. ADDRESS:
25. DATE RECD. BY LOCAL REG.: 4-27-61
26. REGISTRAR'S SIGNATURE: Marguerite Hudgens

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ INSTEAD OF DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 Henry G. Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep. Mo.

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.