

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-017551

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2688

FILED JUN 12 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>10 YEARS</u>	c. CITY OR TOWN <u>North Kansas City, Mo.</u>	Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.C. Tuberculosis Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>4001 Cleveland</u>	Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Christopher</u> Middle <u>Johnston</u> Last <u>Johnston</u>	4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</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>10-31-1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>C.F. Foreman Const. Hastings Nebr.</u>	11. BIRTHPLACE (City and state or country) <u>U.S.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>Walton J. Johnston</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Cantrell</u>	14. NAME OF HUSBAND OR WIFE <u>Myrtle Johnston</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Myrtle Johnston</u> Address <u>4001 Cleveland Mo.</u>
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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>Pulmonary Tuberculosis</u>		INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____
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21. I attended the deceased from March 3 1961 to May 29 1961 and last saw him alive on May 29, 1961
Death occurred at 5:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edward P. Altman</u> (Degree or title)	22b. ADDRESS <u>M.D. K.C. J.B. Hospital</u>	22c. DATE SIGNED <u>5-29-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-31-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>	23d. LOCATION (City, town, or county) <u>Kansas City Mo.</u> (State)
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24. FUNERAL DIRECTOR <u>D.W. Newsome's Sons N.K.R. Mo.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>5-31-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF Edward P. Altman MEDICAL CERTIFICATION

SHOULD READ

ITEM NO.

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 Glenn H. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 78, 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.