

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041104

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5670

STATE FILE NUMBER

AMENDED

DATE PREPARED: 2-1-62
 ITEM NO. SHOULD READ: 18ab Myocardial infarction, acute superimposed on old healed infarct. Perforated duodenum 2/1/62
 BY AFFIDAVIT OF attending physician: Philip D. Reister

Registration District No. 149 Primary Registration District No. 1-002 Registrar's No. 5670

FILED DEC 1 1961

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 lb 54 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 901 East 84th Terr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WALTER Middle S. Last JOHNSON			4. DATE OF DEATH Month November Day 10 Year 1961
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 11-4-1907 9. AGE (last birthday) 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Inspector		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas City, Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Junius Johnson		13b. MOTHER'S MAIDEN NAME Wilhelmina Herman	14. NAME OF HUSBAND OR WIFE Lelia Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			17. INFORMANT Address Mrs. Lelia Johnson 901 E. 84th Terrace
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute superimposed on old healed infarction DUE TO (b) Perforated duodenum DUE TO (c) Coronary arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Duodenal ulcer-- chronic, perforating resected			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio-sclerosis generalized			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 11:15 a.m. Month, Day, Year Nov 10, 1961		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 Feb 1958 to Nov 10, 1961 and last saw him alive on Nov 10, 1961 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Philip D. Reister M.D.		22b. ADDRESS 518 Argyle Bldg	
22c. DATE SIGNED 11/11/61		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 11-13-61	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 11-13-61	26. REGISTRAR'S SIGNATURE Keith Long

Dr Wallace Graham
Argyle 15th
AR 1-0111
DR. REGISTER
Room 518
2-4

STATE OF MISSOURI

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 Ralph O. Grubb

Licensed Embalmer No. 5004

P. O. Address K. C. 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.