

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041105

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5657

STATE FILE NUMBER

FILED DEC 1 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>	a. STATE <u>Kansas</u>	b. COUNTY <u>OSBORNE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>26 days</u>	c. CITY OR TOWN <u>Osborne</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>Box 59</u>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Ward</u>	Middle <u>R.</u>	Last <u>Johnston</u>	4. DATE OF DEATH	Month <u>11</u>	Day <u>12</u>	Year <u>61</u>
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5. SEX <u>male</u>	6. COLOR OR 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>11-10-97</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR	IF UNDER 24 HR		
					Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Harlan Lb. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Elmwood, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>W. J. Johnston</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Kelly</u>	14. NAME OF HUSBAND OR WIFE <u>Romaine Johnston</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. #1</u>	16. SOCIAL SECURITY NO. <u>W. J. #1</u>	17. INFORMANT <u>Mrs. Romaine Johnston - Osborne, Kansas</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:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Carcinoma of maxillary sinus</u>	<u>9 mo.</u>
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 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.)
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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 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 1938 to 12 Nov '61 and last saw him alive on 12 Nov '61
Death occurred at 1:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M. G. Berry M.D.</u>	(Degree or title)	22b. ADDRESS <u>315 Michigan Rd. Kansas City 12 Mo</u>	22c. DATE SIGNED <u>12 Nov 61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-12-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-</u>	23d. LOCATION (City, town, or county) <u>Osborne, Kansas</u>	(State)
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24. FUNERAL DIRECTOR <u>Stine & M^{rs} Clare</u>	ADDRESS <u>3235 S. 11th - Plaza</u>	25. DATE RECD. BY LOCAL REG. <u>11-12-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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K.C. 190 (Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1961 DEC 5 MS

DEC 26 1962

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City

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.