

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6761

1. PLACE OF DEATH

County Jackson
Township 1st
City Kansas City (No. Kansas City Gen Hosp.)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 927
St. _____ Ward _____

2. FULL NAME Peterson Anna

(a) Residence. No. 1802 Garbar St. 3 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wayne Peterson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-5-1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
74 11 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

14. INFORMANT Records Dept
(Address) Kansas City Gen Hosp

15. FILED 2-25-29 W. M. Linn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-24-1929

17. I HEREBY CERTIFY, That I attended deceased from 2-18-1929, to 2-24-1929, 1929, that I last saw him alive on 2-24-1929, and that death occurred, on the date stated above, at 1:35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture of Rt Femur
(accidental fall)
186A 12
1940 (duration) yrs. mos. ds.
100

CONTRIBUTORY (SECONDARY) Robert Pneumonia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (185)
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

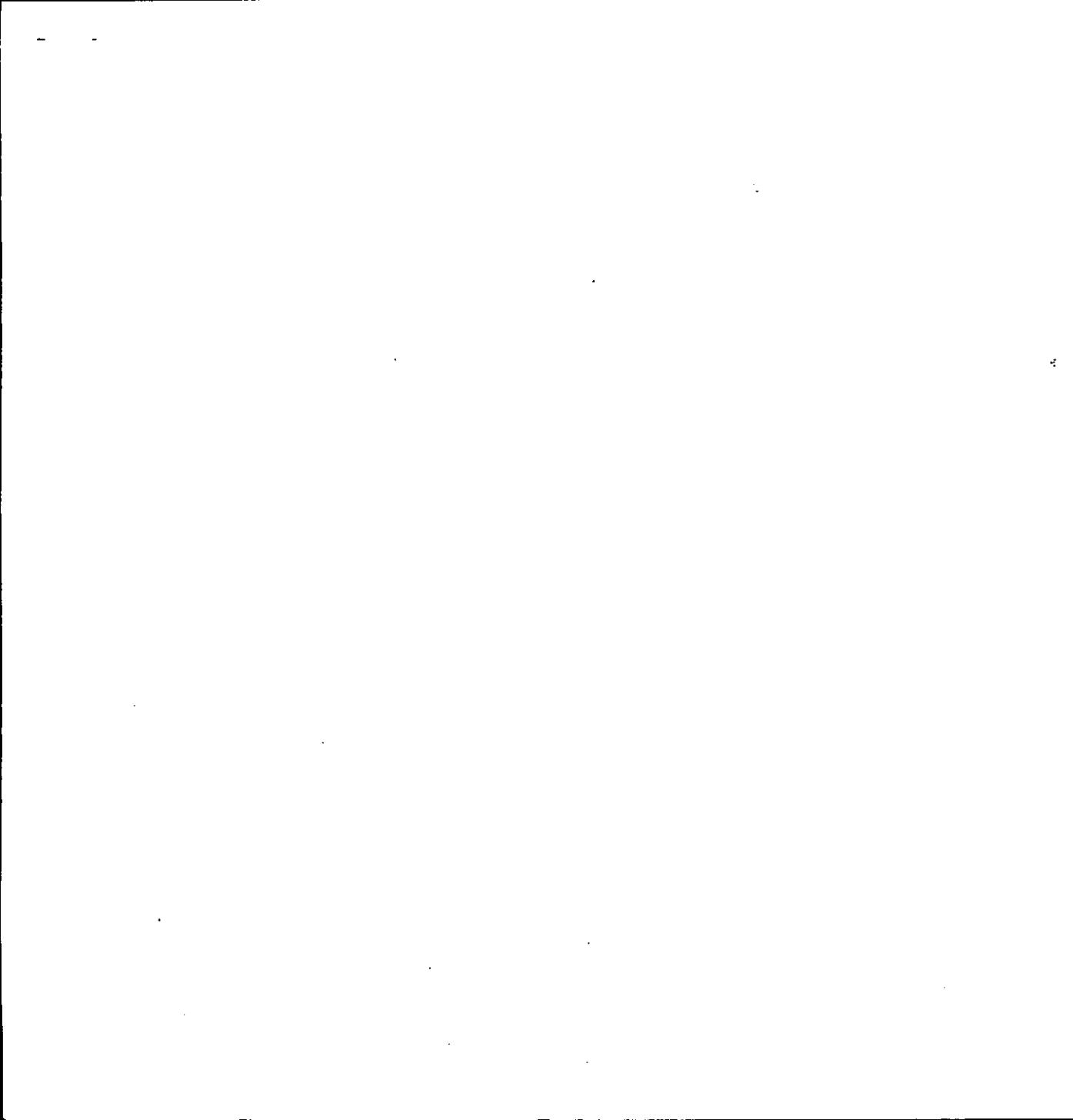
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Harvey Jewett M. D.
2-25-1929 (Address) Post Dept KC Denton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sabrina Kans DATE OF BURIAL 2-25-1929

20. UNDERTAKER J. P. Linn ADDRESS Kansas City Mo



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 927
 City K. City (No.) St. Ward)

2. FULL NAME

Peterson Anna
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-5-1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 11 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) yrs. mos. ds.
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED 3/25 2 9 P. M. Corvill REGISTRAR
Ann

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 - 19 29

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h. alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGIS TARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1979-5