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

35191

1. PLACE OF DEATH
County: Nodaway — Registration District No.: 625 — File No.:
Township: — Primary Registration District No.: 3031 — Registered No.: 96
City: Maryville (No. St. Francis Hospital St. Ward)

2. FULL NAME Hattie Elnora Peterson

(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 31 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) dec 13-1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	58	9	28	

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

9. BIRTHPLACE (CITY OR TOWN) Shelby Co
(STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER James Riley Miller
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Park Co.
(STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Mary Hubbard
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jasper Co
(STATE OR COUNTRY) Iowa

14. INFORMANT Mary Christie
(Address) Ravenwood Mo

15. FILED Oct 13 1931 Mamie E Clardy REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 11 - 1931

17. I HEREBY CERTIFY, That I attended deceased from Sat. Oct 10, 1931, to Oct - 11, 1931 that I last saw h. on alive on Oct 11, 1931, and that death occurred, on the date stated above, at 2:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mesenteric Thrombosis
Intestinal obstruction
99A
122B
133C (duration) yrs. mos. 3 ds
CONTRIBUTORY (SECONDARY) Anemia - acute (duration) yrs. mos. 36 hrs

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Examination
(Signed) Jean Rawlett, M. D
, 19 (Address) Maryville Mo

*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
Oak Lawn Ravenwood	Oct 14 1931
20. UNDERTAKER	**ADDRESS**
Ross & Long	Ravenwood Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ... St. .....Ward)

2. FULL NAME .....

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos. .....ds

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