

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.

REC'D MAY 19 1939

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

15203  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Assess Registration District No. 447  
 (b) Township JOPLIN Primary Registration District No. 3024 Registered No. 41  
 (c) City Wet City (d) Street No. 24 S. HALL St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. 624 S. Hall St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widowed</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept. 6 1854</u>				
7. AGE	YEARS <u>84</u>	MONTHS <u>7</u>	DAYS <u>22</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>at home</u>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Warren Missouri</u>			
	13. NAME <u>J. L. Peterson</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill</u>			
MOTHER	15. MAIDEN NAME <u>Charlton Caspard</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>			
17. INFORMANT (ADDRESS) <u>Miss Elly Conners</u> <u>Wet City, Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL? PLACE <u>Wet City, Mo.</u> DATE <u>April 29 1939</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Wet City, Mo.</u>				
20. FILED APR 29 1939 <u>H. P. Fitchett M.D.</u> Local Registrar				

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-31, 1935, to 4-28-39, 19.....  
 I last saw him alive on 4-8-39, 19..... Death is said to have occurred on the date stated above, at 7:15 m.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Pancreatitis  
Nephritis  
 Date of onset 12/1

Other contributory causes of importance:  
Hypertension

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify.....  
 (Signed) George W. Cox M.D.  
Wet City, Mo.  
 377 (Address)

RECEIVED

District Health Officer No. 6,

District File Number 6-5-39-1021

Date Filed MAY 2 1939

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 Myself,

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 3922

P. O. Address Webb City, 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 this body is not embalmed, above space should be left blank.