

USE GRADING BLOCK INK—MAKE 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1044

JAN 13 1940 399

Primary Registration District No. 1002

Registrar's No. 129

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City 2

(c) Name of hospital or institution: 1630 Summit  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year 36 2  
In this community 36 2 years, months or days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 1630 Summit  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME ALBIN E. PETERSON

(b) If veteran, name war yes

(c) Social Security No. --

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2nd  
year 1940 hour 9 minute 15 A.M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Floca Peterson

6. (c) Age of husband or wife if unobtainable alive \_\_\_\_\_ years

7. Birth date of deceased March 10-1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that he/she was alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>9</u>	<u>12</u>	_____ hr _____ min.

Due to Chronic myocarditis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 92C

9. Birthplace Chicago Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. INDUSTRY OR BUSINESS

12. Name Unknown

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

Mean of injury 5

23. Signature Walter H. Miller (M. D. or other)  
Address K.C. Mo. Date signed \_\_\_\_\_

MOTHER FATHER

16. (a) Informant's own signature Wm. Carl Bangs

(b) Address 2912 E 40, K. C. Mo.

17. (a) Burial (b) Date thereof Jan 11, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wadsworth, Kansas

18. (a) Signature of funeral director J. F. O'Donnell Co.

(b) Address 3256 Broadway K.C. Mo.

19. (a) Jan. 10, 1940 (b) M. M. Craze  
(Date received local registrar) (Registrar's signature)

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2347

P. O. Address..... W. C. Mc

**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.**