No. 2
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FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31096 3659

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hrs. (Specify whether years, months or days)
In this community 43 yrs.

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")
0
(d) Street No. 2638 Elmwood
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Clarence E. Peer

3. (b) If veteran, name war World War

3. (c) Social Security No. 486-10-7941

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Pearl M Peer

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Dec. (Month) 9th. (Day) 1896 (Year)

8. AGE: Years 43 Months 9 Days 28 If less than one day hr. min. 0

9. Birthplace Kansas City, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business K.C. Power & Light Co.

FATHER
12. Name Bowman A. Peer
13. Birthplace U.S.A.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Eleanor Feitch
15. Birthplace U.S.A.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pearl Peer
(b) Address 2638 Elmwood

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/40 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director C.H.Blackman & Son Inc.
(b) Address 2825 Independance Blvd.

19. (a) Sept. 19-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 9-18-40
year hour minute 2:40 P.M.

21. I hereby certify that I attended the deceased from Sept. 15, 19 40, to Sept. 18, 19 40; that I last saw he alive on Sept. 18, 19 40; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (left)
Due to
2° & 3° burns of chest & face
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy yes

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Do not know
(b) Date of occurrence 9-18-40
(c) Where did injury occur? K.C. Mo (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) (e) Means of injury 5

23. Signature Leslie R. Butler (M. D. or other)
Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 H D Blackman

Licensed Embalmer No. 3639

P. O. Address K C Mo

Note:: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

o. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 3659

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

3. (a) PRINT FULL NAME Clarence E Peer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Wh

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

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature) 361

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 1 + 2 nd Deg burns

Due to of Chest + face

Due to

Other conditions (Include pregnancy within 3 months of death) 181

Major findings:
- Of operations
- Of autopsy Yes

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) Not

(b) Date of occurrence 9-18-40

(c) Where did injury occur? K C Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Industrial (Not a Conflagration) (Specify type of place)

While at work? Yes (e) Means of injury Acid Burns

23. Signature V B Buhler (M. D. or other)

Address Date signed

S-31096