

2  
-40  
-39  
C23159

**NOV 12 1940**  
Registration District No. **99**

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  
 (c) Name of hospital or institution: 1113 1/2 East 11 st. **2**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City **0**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1113 1/2 East 11 st.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Evelyn G. Peterson  
 (b) If veteran, name war none (c) Social Security No. none

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Oct - day 29  
 year 1940 hour 12:30 minute A. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 (b) Name of husband or wife Albert A. Peterson 6. (c) Age of husband or wife if alive 30 years  
 7. Birth date of deceased July 2, 1911  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6/18/39 to 10/29, 1940, that I last saw her alive on 10/20, 1940, and that death occurred on the date and hour stated above.

**8. AGE:** Years 29 Months 3 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Acute Thrombosis **sudden**  
 Due to hypertension & atherosclerosis **acute**  
 Due to acute anemia **refr**

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

Other conditions (include pregnancy within 3 months of death)  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**10. Usual occupation** at home  
**11. Industry or business** housewife  
**MOTHER FATHER**  
 12. Name Charles Johnson  
 13. Birthplace Arkansas  
 14. Maiden name Phoebe A. Peterson  
 15. Birthplace Arkansas

Major findings: hypertension 1 yr ago  
 Of operations quiescent  
 Of autopsy acute thrombosis - cardiac  
arteriosclerosis - atherosclerosis

16. (a) Informant Albert A. Peterson  
 (b) Address 1113 1/2 East 11 st.  
 17. (a) removal (b) Date thereof 10/31/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Colleyville Kans  
 18. (a) Signature of funeral director Thos. C. Carson  
 (b) Address Independence, Mo.  
 19. (a) Oct. 30, 1940 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) None  
 (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) (e) Means of injury !  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address 3034 Harrison Date signed 10/29/40

Dr. John S. Hull  
3034 Harrison

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**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 *Frank DeWitt*

Licensed Embalmer No. *2467*

P. O. Address *Indef. Me.*

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

7  
State File No. ....  
Registrar's No. 4150

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. .... Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K.C.  
(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

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME

Evelyn Peterson

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

3. (c) Social Security No.....

4. Sex F 5. Color or race W

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

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 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.....

MOTHER FATHER { 12. Name

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10/30/40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29-40  
year..... 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.....

Renal thrombosis  
Hypernephroma metastatic

Due to Primary Left SB  
Suprarenal Gland  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: Of operation Hypernephroma - 1/2  
age - 40 yrs.  
Of autopsy Tumor of supra  
renal gland.

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).....

(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) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-34634-