

FILED DEC 12 1941
Registration District No. **633**

Primary Registration District No. **5-871**

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

1. PLACE OF DEATH:

(a) County **Pemiscot**
(b) City or town **Goble, Mo.**
(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 **9 months**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Pemiscot**
(c) City or town **Goble, Mo.**
(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 **Othie Peterson**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F.** 3. Color or race **Col** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Gordon Peterson** 6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **Jun. 12 1905**
(Month) (Day) (Year)

8. AGE: Years **36** Months **9** Days **7** hr. _____ min.

9. Birthplace **Rolling Fork Miss.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Jeff. Horn**

13. Birthplace **D. K.** 9
(City, town, or county) (State or foreign country)

14. Maiden name **Georgia Rindler**

15. Birthplace **Rolling Fork Miss.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jeff. Horn**
(b) Address **Rolling Fork, Miss.**

17. (a) **Burial** (b) Date thereof **Oct 21/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Goble, Mo.**

18. (a) Signature of funeral director **Shelby Service**
(b) Address **Pemiscot Mo.**
19. (a) **11/21/41** (b) **Pearl Kelley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **18.**
year **1941** hour **7:42** minute **0** M.

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

Immediate cause of death **After effect of**
the major abdominal
Due to operation performed
by Dr. Hill, D. K. Hill, Ark.
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? **9**

While at work? _____ (Specify type of place) (e) Means of injury **9**

23. Signature **July V. Moore** (M. D. or other) **Coroner**
Address **Rolling Fork, Miss.** Date signed **10/17/41**

12-41-9

4.2.
P-110

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 A. C. Lunsdell

Licensed Embalmer No. 818

P. O. Address Kennett 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39025

Registration District No. 653

Primary Registration District No. 5871

Registrar's No.

1. PLACE OF DEATH

- (a) County Plymouth
- (b) City or town Summer
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME

Athie Peterson

- 3. (b) If veteran, name war _____
- 3. (c) Social Security No. _____

- 4. Sex M.
- 5. Color or race B.
- 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 Jan. 12, 1903
(Month) (Day) (Year)

8. AGE: 36 Years 9 Months 9 Days (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1991 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: after effects of a major abdominal operation performed by Dr. Wahl.

Due to: Husband did not know nature of operation, and was unable to contact Dr. Wahl.

Other condition (Include pregnancy within 3 months of death): Major findings: history would indicate Pyloric or septicemia

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 Jules O. Moore (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-39025