

FILED FEB 24 1944

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 675

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: St. Mary's Hosp
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution 8 wks
In this community 6 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 1327 Cherry
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Germany

3. (a) PRINT FULL NAME Augusta Petermann

3. (b) If veteran, name war ✓ 3. (c) Social Security No. none

4. Sex fe 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow

6. (b) Name of husband or wife Joseph Petermann 6. (c) Age of husband or wife if alive, _____ years

7. Birth date of deceased July - 15 - 1872
(Month) (Day) (Year)

8. AGE: Years 71-63 Months 6 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Thomas

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Marie Severin

(b) Address 1327 Cherry

17. (a) removed (b) Date thereof Feb. 10 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbus 988

18. (a) Signature of funeral director A. P. Daehler

(b) Address 1415 E. 15
19. (a) 2-10-44 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9th
year 1944 hour 10 minute 159 M.

21. I hereby certify that I attended the deceased from 12/4/43
_____, 19____, to 2/9, 1944
that I last saw her alive on 7/8, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Nephritis,
Due to Chronic Nephritis
Due to Diabetes
Other conditions _____
(Include pregnancy within 3 months of death)

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

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?
While at work? _____ (Specify type of place)
(e) Means of injury 0

23. Signature James Brown (M. D. or other)
Address 804 Park Blvd Date signed 7/9/44

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

Porter Blady

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 *J.P. Doehler*.....

Licensed Embalmer No. *1166*.....

P. O. Address *1415 E 15*.....

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.