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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUN 3 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17140

State File No. ....

2241

Registration District No. .... 49

Primary Registration District No. .... 1002

Registrar's No. ....

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: Little Sisters of the Poor  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 years and 9 months  
(Specify whether years, months or days)  
In this community 60 years  
(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. 1703 Jefferson  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

ELIA M. PECK

(b) If veteran, name war No

(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 Unknown

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

7. Birth date of deceased Oct. 23, 1899  
(Month) (Day) (Year)

8. AGE: Years 84 Months 83 Days 7 0  
If less than one day hr. min.

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

10. Usual occupation Nurse

11. Industry or business Retired

MOTHER FATHER

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)

16. (a) Informant Mrs. Paul Kemble

(b) Address 1703 Jefferson

17. (a) Burial (b) Date thereof 5-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address Kansas City, Mo.

19. (a) 5-24-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23  
year 1944 hour 12 minute Midnight

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 Cerebral thrombosis  
Due to arteriosclerosis  
Duration 3 days  
years

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none

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?

(e) While at work? \_\_\_\_\_ (Specify type of place) (f) Means of injury \_\_\_\_\_

Signature John T. Skinner (M. D. or other) M.D.

Address 1102 Grand Ave. Date signed 5-27-44

R. C. MO

**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.....

P.O. Address.....

**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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. June  
Registrar's No. 2241

Registration District No. 149

Primary Registration District No. 1002

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

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

3. (a) PRINT FULL NAME Ella M. Peck

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

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

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..... 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.....

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) June 5 1944 (b) J. E. Brown (c) (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 May day 23<sup>rd</sup> year 1944 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from May 13 1944 to 5 23 1944 that I last saw her alive on 5 23 1944 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
.....  
.....

Due to.....  
.....  
.....

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

Major findings:  
Of operations.....  
.....  
Of autopsy.....

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 John T. Shannon (M. D. or other)

Address 76 mo. Date signed.....

17140