

S. No. 2  
-12.45  
5-17-39  
P I X47070

FILED MAR 3 1947  
Registration District No. **1947**

Primary Registration District No. **1002**

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: **General Hospital No. 1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**  
(Specify whether years, months or days)

In this community **2 days**

3. (a) PRINT FULL NAME **William Peebles**

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

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

4. Sex **Male** 5. Color or race **Wh**

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

6. (b) Name of husband or wife **Bertha Peebles**

6. (c) Age of husband or wife if alive **No Record** years

7. Birth date of deceased: **May 14 1875**  
(Month) (Day) (Year)

8. AGE: **71** Years Months **8** Days **27**  
If less than one day hr. min.

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

10. Usual occupation **Retired**

11. Industry or business

12. Name **Elie Peebles**

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

14. Maiden name **No Record**

15. Birthplace **No Record**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Bertha Peebles**

(b) Address **Buffalo Mo**

17. (a) **Burial** (Burial, cremation, & removal) (b) Date thereof **Feb 13 47**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Buffalo Mo**

18. (a) Signature of funeral director **L. M. Jones**

(b) Address **Buffalo Mo**

19. (a) **2-15-47** (Date received local registrar)

(b) **Geraldine Holmes** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **30**

(c) City or town **Buffalo Mo.** (If outside city or town limits, write "RURAL") **2**

(d) Street No. (If rural, give location) **1**

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **11** year **1947** hour **7** minute **30** A. M.

21. I hereby certify that I attended the deceased from **Feb. 9** 19**47** to **Feb. 11** 19**47**  
that I last saw him alive on **Feb. 11** 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death. **Generalized arteriosclerosis**  
**Coronary arteriosclerosis**  
**Acute coronary insufficiency**

Due to

Due to

Other conditions (include pregnancy within 3 months of death) **93d**

Major findings: Of operations

Of autopsy **See above**

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 **W. W. Hart** (M. D. or other) **Med. Dir. Gen'l Hosp.**  
Address **2-11-47** Date signed

Dr. Hicks  
Dr. Hargrove

---

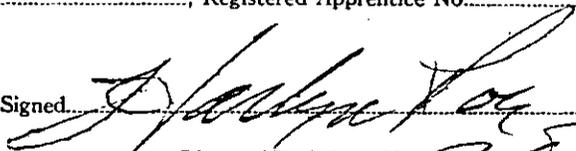
---

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. 2510

P. O. Address K. C. Ill.

**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.