

S. No. 2
 4-8-43
 5-17-39
 PI X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED MAR 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12301**

Registration District No. **379**

Primary Registration District No. **6287**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County WRIGHT
 (b) City or town PIPASANT VALLEY TWP. RURAL
(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 3 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County WRIGHT
 (c) City or town MANSEFIELD - RURAL
(If outside city or town limits, write "RURAL")
 (d) Street No. PIPASANT VALLEY TWP. - 1/2 MI. EAST
(If rural, give location)
 (e) Citizen of foreign country? MANSEFIELD (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ROBEN GLEN PEDERSEN

3. (b) If veteran, name war NONP 3. (c) Social Security No. 494-101-3292

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

6. (b) Name of husband or wife ETHEL MARIE PEDERSEN 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Feb 19 1902
(Month) (Day) (Year)

8. AGE: Years 45 Months 0 Days 19 If less than one day _____ hr. _____ min.

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

10. Usual occupation LANDOWNER

11. Industry or business _____

12. Name Peder G. Pedersen

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

14. Maiden name Quais S. Yockey

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

16. (a) Informant Olens L. Neal
 (b) Address Manfield Mo - R4

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

(c) Place: burial or cremation MANSEFIELD CEMETERY

18. (a) Signature of funeral director G.A. Steffe
 (b) Address MANSEFIELD MO

19. (a) 3/13/47 (b) Mapine Davis, Dept.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month MARCH day 8
 year 1947 hour 9 minute 10 P. M.

21. I hereby certify that I attended the deceased from Feb 15
 1947 to Mar 8 1947
 that I last saw h E alive on Mar 6 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Lobar) Duration 3 days

Due to Influenza 1 week

Due to Pulmonary Tuberculosis 3 yrs

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

Major findings: 2 B
 Of operations _____
 Of autopsy _____

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 H. H. H. H. H. (D. or other) _____
 Address Manfield Mo Date signed 3-12-47

RECEIVED

District Health Officer No. 6;

District File Number 347-361

Date Filed MAR 18 1947

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

F. A. Steffe

Licensed Embalmer No. 3221

P. O. Address Manfield 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, fact should be so stated above.