

FILED FEB 20 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **5022**  
 Registrar's No. **617**

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 Jackson  
 (b) City or town K.C. Mo  
 (c) Name of hospital or institution 558 Main  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community unknown years, months or days

**3. (a) PRINT FULL NAME** NIKOLA PETROUICH  
**3. (b) If veteran,** name war unknown **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** M **5. Color or race** O **6. (a) Single, widowed, married, divorced** single  
**6. (b) Name of husband or wife** unknown **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** unknown  
 (Month) (Day) (Year)

**8. AGE:** 59 Years 69 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

**10. Usual occupation** \_\_\_\_\_

**11. Industry or business** unknown

**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** Coroner's office

**(b) Address** K.C. Mo.

**17. (a) Removal** Removal **(b) Date thereof** 2/11/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Mt Calvary Cem K.C. Mo.

**18. (a) Signature of funeral director** Sebbels

**(b) Address** city

**19. (a) 2-11-48** **(b) Geraldine Holmes**  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Jackson  
 (c) City or town K.C (If outside city or town limits, write "RURAL.")  
 (d) Street No. 558 Main  
 (If rural, give location)  
 (e) Citizen of foreign country? unknown (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month 2 day 6  
 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from** born \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

**Immediate cause of death** Coronary thrombosis  
**Due to** arteriosclerosis

**Due to** \_\_\_\_\_

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

**Major findings:** \_\_\_\_\_  
 Of operations \_\_\_\_\_  
**Of autopsy** no  
history of hypertension

**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) **(c) Means of injury** \_\_\_\_\_

**23. Signature** [Signature] (M. D. or other) \_\_\_\_\_  
**Address** 1927 1/2 W. Main **Date signed** 2-10-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

033 0234

**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 \_\_\_\_\_

*Ray E. Snow*  
Licensed Embalmer No. 2560

P. O. Address K. E. M.

**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.**