

FILED FEB 16 1948

3032

Registrar's No. **11**Registration District No. **11.44**Primary Registration District No. **3032**

1. PLACE OF DEATH:

(a) County **Johnson**
 (b) City or town **Waldenburg**
 (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) **3**
 (d) Length of stay: In hospital or institution **Died**
 In this community **On way to Hospital** (Specify whether
 years, months or days) **From Corder, Mo.**

3. (a) PRINT
FULL NAME**William H. Petty**3. (b) If veteran,
name war

3. (c) Social Security

No. **500-14-0870**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married,
divorced **Married**
 6. (b) Name of husband or wife **Gena Petty** 6. (c) Age of husband or wife if
alive **53** years
 7. Birth date of deceased **Jan 5th 1887**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 **---** **24** hr. min.

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

10. Usual occupation **Miner**

11. Industry or business

12. Name **William Z. Petty**

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

14. Maiden name **Nettie Reed**

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

16. (a) Informant **Gena Petty**

(b) Address **Horder, Missouri.**

17. (a) **Burial** (b) Date thereof **2 / 3 / 1948**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Corder Cemetery**

18. (a) Signature of funeral director **W. H. ...**

(b) Address **Higginsville, Mo.**

19. (a) **Feb. 2, 1948** (b) **Sanannah ...**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette**
 (c) City or town **Corder,**
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **29th**
 year **1948** hour **9** minute **30** P.M.

21. I hereby certify that I attended the deceased from **Jan. 28**
 19 **48** to **Jan. 29**, 19 **48**;
 that I last saw him alive on **Jan. 29th**, 19 **48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute endocarditis** Duration

Influenza

Due to

Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations

Of autopsy

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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

Signature **Sanannah ...** (M. D. or other)
 Address **Higginsville, Mo.** Date signed **1/30/48**

JUL 28 1948

0130-11-1-13

MAY 1 1948

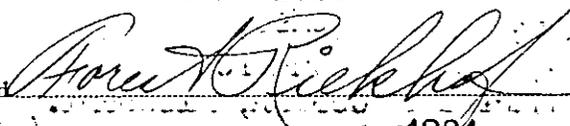
STATEMENT BY LICENSED EMBALMER

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. 4284

P. O. Address Higginsville, 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.

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
Name of hospital or institution:
In Ambulance (transported)
(If not in hospital or institution, write street, city, and county)
(d) Length of stay: In hospital or institution specify whether
died a way to
In this community Hospital
years, months or days

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

William H. Petty

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

3. (c) Social Security No. 500-140570

20. DATE OF DEATH: Month 12 Day 9 Year 1948
hour..... minute..... M.

21. I hereby certify that I attended the deceased from 1948 to 1948 at Warrensburg, Mo. and that death occurred on the date and hour stated above. Immediate cause of death.....

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 61 Months 1 Days 1 If less than one day hr. min.

9. Birthplace Mo (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (Registrar's signature) Saravali Chutkita

MEDICAL CERTIFICATION
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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-5321 - 1948