

FILED AUG 26 1948

Registration District No. **749**

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:
2615 Rochester St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In-hospital or institution **no** (Specify whether
In this community **25 yrs.** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2615 Rochester St.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3: (a) PRINT FULL NAME **PETERS, John A.**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **496-07-2518**

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

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

7. Birth date of deceased **3/26/1880**
(Month) (Day) (Year)

8. AGE: Years **68** Months **4** Days **5** If less than one day hr. min.

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

10. Usual occupation **Retired**
11. Industry or business **Laborer**

12. Name **Adolph Peterson**
13. Birthplace **Sweeden**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Maria Anderson**
15. Birthplace **Sweeden**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henry Peterson**
(b) Address **623 - 44th St., Rock Island, Ill**

17. (a) **Removal** (b) Date thereof: **8/4/48**
(Partial exhumation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rock Island Ill**

18. (a) Signature of funeral director **John P. Schind**

(b) Address **Kansas City**

19. (a) **8-2-48** (b) **Suzaldene Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **1**
year **1948** hour **12** minute **30** P.M.

21. I hereby certify that I attended the deceased from _____, 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 Sclerosis** Duration _____

Due to _____

Due to _____

Other conditions **g3d**
(Include pregnancy within 3 months of death) **Deputy Coroner**

Major findings: **History & Inspection** PHYSICIAN _____

Of operations _____
Of autopsy _____
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) (Specify type of injury)

23. Signature **A. E. Walker** (M.D. or Physician)

Address **2800 Main** Date **8/1/48**

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

John P. Shuck

Licensed Embalmer No.

3625

P. O. Address

166 2nd

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.