

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040327

STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 502

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Independence		c. CITY OR TOWN Independence	
c. FULL NAME OF HOSPITAL OR INSTITUTION West Haven		d. STREET ADDRESS 1500 Truman Rd	

3. NAME OF DECEASED (Type or print) Lillie Peterson			4. DATE OF DEATH Month Day Year 701-29-1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10-1875	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	10b. KIND OF BUSINESS OR INDUSTRY Homemaking	11. BIRTHPLACE (City and state or country) Delater Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown Ackerly	14. NAME OF HUSBAND OR WIFE J. W. Petersen
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs Fern Maunum Burlant Caley	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) coronary arteriosclerosis	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4201
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20c. TIME OF INJURY	Hour Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 4/4/58 to 11-29-58 and last saw her alive on 11/26/58	Death occurred at 700 A m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Vance E. Link, M.D.	22b. ADDRESS 10901 Winner, Indep., Mo.	22c. DATE SIGNED 11-29-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 2/58	23c. NAME OF CEMETERY OR CREMATORY Mount Zion	23d. LOCATION (City, town, or county) (State) Gladys, Mo.
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24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG. 12-2-58	26. REGISTRAR'S SIGNATURE Vance E. Link
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Rollie Fessel*

Licensed Embalmer No. *4690*

P. O. Address *Indep. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.