

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010301
STATE FILE NUMBER

LEO APR 7 1959 Registration District No. 231 Primary Registration District No. Registrar's No. 82

300
1-57

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN White Cloud <i>Twp</i>		c. CITY OR TOWN Bolckow <i>6740</i>	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If outside, give location) 4 mile NW	

3. NAME OF DECEASED (Type or print) First JAMES Middle Last PETERSON			4. DATE OF DEATH Month March Day 30 Year 1959		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1873	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days	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) farmer	10b. KIND OF BUSINESS OR INDUSTRY OWN farm	11. BIRTHPLACE (City and state or country) Denmark <i>4</i>	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Marius Peterson	13b. MOTHER'S MAIDEN NAME Kirsten	14. NAME OF HUSBAND OR WIFE none
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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. -----	17. INFORMANT Address Ike Wilson RFD #1 Bolckow <i>Mo</i>
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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) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 6 wks 5 yrs. 4200
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized atherosclerosis	
	DUE TO (c) Stroke	
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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 1-8-59 to 3-30-59 and last saw him alive on 3-28-59 Death occurred at 7:05 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) Savannah	22b. ADDRESS Savannah Mo	22c. DATE SIGNED 3-30-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Mar. 30, 1959	23c. NAME OF CEMETERY OR CREMATORY Bolckow Cemetery	23d. LOCATION (City, town, or county) (State) Bolckow, Missouri
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24. FUNERAL DIRECTOR ADDRESS Breit Funeral Home, Savannah, Mo.	25. DATE RECD. BY LOCAL REG. 3-30-59	26. REGISTRAR'S SIGNATURE Bess Holt
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Doctor, coroner, etc. must use only standard nomenclature in item 10. NO symptoms with no cause. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *James B. Hawkins*

Licensed Embalmer No. *4536*

P. O. Address *Savannah*

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.