

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025350

FILED VS JUL 27 1959 49

Registration District No. 1002 Primary Registration District No. Registrar's No. 3351

STATE FILE NUMBER

DED

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 45 Yrs		c. CITY OR TOWN Kansas City 2732 Troost		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Willie Boarding Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2732 Troost		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MATILDA Middle FRANCES Last PEEK				4. DATE OF DEATH Month July Day 6 Year 1959					
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 Jan 25 1871 88		9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) Leavenworth Kansas		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME William Johnson			13b. MOTHER'S MAIDEN NAME Mary			14. NAME OF HUSBAND OR WIFE John Peek (Dec)			
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 Address Fred Farmer 1109 Ellth St Kansas City MO				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH MINUTES		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arterio sclerosis							YEARS		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year							
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	
21. I attended the deceased from 7-2-59 to 7-6-59 and last saw her/him alive on 7-2-59 Death occurred at 8:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) M. A. Cline M.D.				22b. ADDRESS 4126 St. John				22c. DATE SIGNED 7-7-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7/9/59	23c. NAME OF CEMETERY OR CREMATORY Mt Calvary		23d. LOCATION (City, town, or county) (State) Kansas City Kansas				
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo				25. DATE RECD. BY LOCAL REG. 7-8-59		26. REGISTRAR'S SIGNATURE Neva Minshel			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. A. Cline

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Thomas A. Hill

Licensed Embalmer No. 4954

P. O. Address K.C. 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.