WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Jasper

Township ~~[illegible]~~

or

Village Reeds

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 415 File No. 41434-1

Primary Registration District No. 4247 Registered No. 2

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Isaac Peterson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (~~Write the word~~): Married

DATE OF BIRTH: August 28, 1855 (Month) (Day) (Year)

AGE: 60 yrs. 11 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Dallas County Mo

PARENTS

NAME OF FATHER: Frank Peterson

BIRTHPLACE OF FATHER (City or town, State or foreign country): unknown

MAIDEN NAME OF MOTHER: Connie Thompson

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl Peterson

(ADDRESS) Reeds Mo.

Filed 8/10, 1917. G H Bragdon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 8 (Month) 8 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 8, 1916, to Aug 8, 1916, that I last saw him alive on Aug 8, 1916, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Lesions of Heart

79

(Duration) _____ yrs. 7 weeks ds.

Contributory (SECONDARY) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J H Graven M. D.

8/9 1916 (Address) Sarcoxie Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Reeds Cemetery

DATE OF BURIAL: 8/9 1916

UNDERTAKER: Davis Mfg Co

ADDRESS: Reeds Mo.

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

MISS...

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1 _____ (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS

...ANLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.