FEB 25 1927

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

Do not use this space.

941

File No. .....
Registered No. 15

1. PLACE OF DEATH
County Jackson Registration District No. 398
Township Blue Primary Registration District No. 554
City Mt Washington (No. 219, Kentucky St. ..... Ward)

2. FULL NAME Hiram Collins Peterie
(a) Residence. No. 219 Kentucky St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
m	wh	widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 13, 1851

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	2	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ill.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) "
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) "
(STATE OR COUNTRY)

14. INFORMANT Simil. O. Peterie
(Address) 219 Kentucky

15. FILED Jan 13, 1927 Dr. F. L. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 10 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1926, to Jan 9, 1927, that I last saw him alive on Jan 9, 1927, and that death occurred, on the date stated above, at 2 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Endocarditis
4 4 R
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Stomach
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. Cannaday Crews M. D.
1/10, 1927 (Address) 6520 Paseo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Laredo, Mo.
DATE OF BURIAL 1/11 1927

20. UNDERTAKER D. W. Neeconner's Sons
ADDRESS K. C. Mo

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.

THIS IS A PERMANENT RECORD

6520 Indep. Ave.
Bern 0756.