

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

Do not use this space.
 9296

APR 27 1927

PLACE OF DEATH
 County Randolph Registration District No. 730
 Township _____ Primary Registration District No. 3034
 City Moberly (No. 120 So Clark)
 Registered No. 62
 St. 2nd Ward

2. FULL NAME Mrs Jennie Pedersen
 (a) Residence. No. 120 So Clark St., 2nd Ward.
 (Usual place of abode)
 (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) No data

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>about.</u>	<u>68</u>			

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Pa

10. NAME OF FATHER David Morgan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Elizabeth Chapman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Pa

14. INFORMANT O O Ash
 (Address) Moberly Mo

15. FILED 3/12 1927 Thos D Fleming
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 21st 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1926, to March 21, 1927, and that I last saw h^e alive on March 21, 1927, and that death occurred, on the date stated above, at 3:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Arteriosclerosis (chronic)
900
 (duration) 10 yrs. ___ mos. ___ ds.
 CONTRIBUTORY Arteriosclerosis
 (SECONDARY) (duration) 5 yrs. ___ mos. ___ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: same
 DID AN OPERATION PRECEDE DEATH: no DATE OF: _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS: no
 (Signed) O O Ash, M. D.
3-22, 19 27 (Address) Moberly Mo

*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 Grand Island Neb DATE OF BURIAL 3-24-27

20. UNDERTAKER Mahan and Son ADDRESS Moberly 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.

RECORD THIS IS A PERMANENT RECORD

