

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

Do not use this space.

33660

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 200
 Township Kear Primary Registration District No. 1002 Registered No. _____
 City N.C.Mo. (No. 2117 Montgall Avenue St. _____ Ward _____)

2. FULL NAME

Christina Johnson Peterson
 (a) Residence. No. 2117 Montgall St. 11 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. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Olaf A. Peterson
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-24-1863
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
65 | 4 | 30 | _____ | _____
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (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) Sweden

10. NAME OF FATHER Nelson Johnson
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Sweden
 12. MAIDEN NAME OF MOTHER No Record
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) No Record

14. INFORMANT Charles Peterson
 (Address) 6010 Paseo av

15. FILED 10/15 1928 M. M. Crowe REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14, 1928
 17. I HEREBY CERTIFY, That I attended deceased from June, 1928, to Oct-13, 1928 that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 7:30 AM _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Atherosclerosis
460 (duration) 2 yrs. _____ mos. _____ da.
45

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY _____
 WHAT TEST CONFIRMED DIAGNOSIS? X Ray
 (Signed) J. F. Park M. D.
10/15, 1928 (Address) 220 W-12 St

*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 Forest Hill DATE OF BURIAL Oct 16, 1928

20. UNDERTAKER Mrs. C. L. Foster ADDRESS N.C.Mo.

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.

220 W. 12th