Be 2030

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

Do not use this space.

1865

1. PLACE OF DEATH
County Jackson
Township Kaw
City K.C. Mo

Registration District No. 399
Primary Registration District No. 1002
(No. 4670 - E - 37th Ter St. ..... Ward)

File No. .....
Registered No. 458

2. FULL NAME Carrol Lee Pedersen
(a) Residence. No. 4670 - E - 37th Ter St., 16 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 M
4. COLOR OR RACE Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26 - 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	1	1	2	

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

9. BIRTHPLACE (CITY OR TOWN) K C
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Al F Pedersen
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Iowa
12. MAIDEN NAME OF MOTHER Myrtle May White
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Kans

14. INFORMANT Al F. Pedersen
(Address) 4670 - E - 37th Ter

15. FILED 1-29, 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 28 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1929, to 1-28, 1929
that I last saw him alive on Jan 28, 1929, and that death occurred, on the date stated above, at 4:15 .m.

THE CAUSE OF DEATH* was as follows:
Mucous Colitis
1138
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Inanition
(duration) ..... yrs. 2 mos. ..... ds.

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?
(Signed) Tom Vaught, M. D
1/29, 1929 (Address) 1701 Jackson

*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 Mt Washington
DATE OF BURIAL Jan 30 1929

20. UNDERTAKER Robt Henderson
ADDRESS 15th Jackson

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.

—Sanger— Elm o632-W.