FILED OCT 11 1940

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30943

Registrar's No. 3506

Registration District No. 399--

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1230 Cleveland St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ?
(Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1230 Cleveland St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Jessie Pegan

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Robert Pegan

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 1 (Day) 1868 (Year)

8. AGE: Years 72 Months 6 Days 5 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Same

FATHER
12. Name J. Farrington
13. Birthplace (City, town, or county) Vermont (State or foreign country)

MOTHER
14. Maiden name Sarah Burnent
15. Birthplace (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Electa Farrington
(b) Address 1230 Cleveland St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ 7/40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Rose & Henderson
(b) Address 4139 E. 15th St. K.C. Mo.

19. (a) Sept. 6, 1940 (Date received local registrar) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5 year 1940 hour 11 minute A. M.

21. I hereby certify that I attended the deceased from Aug. 18, 1940 to Sept 5, 1940 that I last saw her alive on Sept. 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Carcinoma of Sigmoid and Rectum — one & half years

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN — 46
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Max H. Keefer (M. D. or other)

Address 1701 Jackson Ave. Date signed 9/7-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____ working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 3506

SUPPLEMENTARY

1. PLACE OF DEATH

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Jessie Pegan

3. (b) If veteran name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 9/6/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 5 - 40
year hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Sigmoid + rectum - Colon

Due to Primary site of Malignancy

Due to M rectum

Other conditions
(Include pregnancy within 3 months of death)

46

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature M. H. Keefer (M. D. or other) MD
Address 1701 Jackson Ave Date signed

S-39943