DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39024

Registration District No. 460 Primary Registration District No. 4274 Registrar's No. 58

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Higginsville (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 3 (Specify whether years, months or days)
In this community Four years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Johnson
(c) City or town Warrensburg (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 Horace W Peters
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Martha Peters
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 25 (Day) 1857 (Year)

8. AGE: Years 83 Months 8 Days 18 If less than one day hr. min.

9. Birthplace Johnson co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Retired Merchant
11. Industry or business
FATHER
12. Name John W Peters
13. Birthplace Fe (City, town, or county) Tenn (State or foreign country)
MOTHER
14. Maiden name Kittie R Lea
15. Birthplace (City, town, or county) Tenn (State or foreign country)
16. (a) Informant's own signature O. L. Peters
(b) Address Jefferson city Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof Nov (Month) 15 (Day) (Year)
(c) Place: burial or cremation Warrensburg
18. (a) Signature of funeral director S R Sumner
(b) Address Warrensburg Mo
19. (a) Nov-30-40 (Date received local registrar) (b) Tipprug Webb (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13 year 1940 hour 10 minute P M.
21. I hereby certify that I attended the deceased from Nov 7 -40, 19__, to Nov 13, 1940; that I last saw him alive on Nov 13, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	
Lymphatic Leukemia	
Due to Secondary Anaemia	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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 Ernest W Moore (M. D. or other) MD
Address Higginsville Mo Date signed 11-14-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 8-17-39 1 X19511

RECEIVED
District Health Officer No. 8,

District File Number.....

Date Filed 12-5-40

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 with the above constitutes grounds for revocation of license.)

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