

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

Jackson

(a) County Kansas City
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K. C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community wife
years, months or days)

3. (a) PRINT FULL NAME Lula Peters

8. (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 Married

6. (b) Name of husband or wife Frank Peters 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Mar 21 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 9 Days 7 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas M. Council

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

14. Maiden name Mary Jackson

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

16. (a) Informant Frank Peters

(b) Address 3213 Cleveland

17. (a) Removal (b) Date thereof Dec 30 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo

18. (a) Signature of funeral director Frank J. Foster

(b) Address 718 Brooklyn

19. (a) 12-30-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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. 3213 Cleveland
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28th
year 1940 hour 9 minute 20 P. M.

21. I hereby certify that I attended the deceased from Dec. 12th 1940, 19____, to Dec. 28th 1940, 19____; that I last saw her or alive on Dec. 28th 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease

Due to Malignant hypertension

Due to _____

Other conditions None
(include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Drury R. Shaw (M. D. or other)

Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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

Renzil C. Browning

Licensed Embalmer No. *2729*

P. O. Address *R. C. M. O.*

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.