

FILED MAY 12 1942

Registration District No. 299

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution April 6 - 22  
(Specify whether in this community years, months or days) 4 years

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. 5618 Indef. ave  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Ardis Elaine Peterson

3. (b) If veteran, name war 760

3. (c) Social Security No. 486-07-609

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife unk

6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased Aug. 9th 1916  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>25</u>	<u>8</u>	<u>13</u>	.....hr. ....min.

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

10. Usual occupation Secretary

11. Industry or business

12. Name A.A. Peterson

13. Birthplace Little River - Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Mina Spain

15. Birthplace Leas Summit Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mina Peterson

(b) Address Little River, Kansas

17. (a) Removal (b) Date thereof 4-23-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McPherson Kansas

18. (a) Signature of funeral director James M. Crow

(b) Address Kansas City MO

19. (a) 4-23-42 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22  
9 year 1942 hour 7:50 minute P M.

21. I hereby certify that I attended the deceased from April 6 1942 to April 22 1942  
that I last saw her alive on April 22 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death post diphtheric lung abscesses

Due to 10

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations .....

Of autopsy see above

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 Dr. R. Thoson (M. D. or other) .....

Address Med. Dir. General 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

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**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..... *Clarence W. Chiles*.....

Licensed Embalmer No..... *3473*.....

P. O. Address..... *Memphis*.....

**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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1600

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

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: General Hospital #1  
(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)

3. (a) PRINT FULL NAME Ardis Elaine Peterson

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

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
	<u>25 yrs.</u>			hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

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 10/11/42 (c) M. M. Crow (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (c) 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.

19. MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month April day 22nd  
 year 1942 hour 7 minute 50 P. M.

21. I hereby certify that I attended the deceased from April 6th 1942 to April 22nd 1942; that I last saw her alive on April 22nd 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia with multiple abscesses, emphysema left chest.

Due to.....

Other conditions (Include pregnancy within 3 months of death) 107

Major findings: Of operations.....

Of autopsy.....

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?

While at work? (Specify type of place) (7) Means of injury.....

23. Signature Mary R. Thore (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTAL

13499