

FILED JAN 11 1943

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson  
(a) County.....  
(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 No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution, 9 hours  
(Specify whether years, months or days) unknown

2. USUAL RESIDENCE OF DECEASED: 48  
(a) State..... Missouri (b) County..... Jackson 3  
(c) City or town..... Kansas City F  
(If outside city or town limits, write "RURAL")  
(d) Street No. 104 West 4th St.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country..... 0

3. (a) PRINT FULL NAME James Peters  
3. (b) If veteran, name war No record 3. (c) Social Security No. none

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Nov. 8th 1895  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>1</u>	<u>15</u>	hr. min.

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

10. Usual occupation..... None recorded

11. Industry or business.....

MOTHER FATHER { 12. Name..... Jerome Peters  
13. Birthplace..... Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name..... Jane Welch  
15. Birthplace..... Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant..... Record Clerk  
(b) Address..... K.C. General Hospital

17. (a) Burial (b) Date thereof 12-28-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Calvary  
18. (a) Signature of funeral director..... Wm. A. Johnson  
(b) Address..... City, Missouri

19. (a) 12-28-42 (b) M. M. Crane  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23rd  
year 1942 hour 9:00 P.M. minute..... M.

21. I hereby certify that I attended the deceased from 12-23-42 19..... to 12-23-42 19.....  
that I last saw him... alive on 12-23-42 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Perforated gastric ulcer with generalized peritonitis

Due to..... 117 a'

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

Major findings:  
Of operations.....  
Of autopsy..... None

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?

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

23. Signature Dr. R. Thom (M. D. or other).....  
Address Med. Dir. K.C. Gen. Hospital Date signed.....

July 1964

**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, fact should be so stated above.**