

**FILED MAR 31 1943**

Registration District No. **149**

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: **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 days**  
(Specify whether **58 yrs.**)  
In this community **58 yrs.**  
(years, months or days)

3. (a) PRINT FULL NAME **James Peppard**

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

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **ANNA F. PEPPARD** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **DECEMBER 7 1884**  
(Month) (Day) (Year)

8. AGE: Years **58** Months **3** Days **16** If less than one day **hr. min.**

9. Birthplace **KANSAS CITY MISSOURI**  
(City, town, or county) (State or foreign country)

10. Usual occupation **CITY TRUCK REPAIRS.**

11. Industry or business

12. Name **OLIVER PEPPARD**

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

14. Maiden name **KATE DEVITY**

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

16. (a) Informant **MRS MAXINE WARNER**

(b) Address **2520 CYPRESS**

17. (a) **BURIAL** (b) Date thereof **3-26-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. WASHINGTON**

18. (a) Signature of funeral director **Holliday M. Kelley**

(b) Address **K.C., MO.**

19. (a) **3-24-43** (b) **M. M. Brown**  
(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. **2520 Cypress**  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **23rd**  
year **1943** hour **12** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **3-14-43** 19... to **3-23-43** 19...  
that I last saw him alive on **3-23-43** 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac asthma**

Due to **asc**

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) (e) Means of injury  
23. Signature **Drury P. Thomas** (M.D. or other)  
Address **Med. Dir. K.C. Gen. Hospital** Date signed

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

MOTHER FATHER

#8

**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 Russell W. France

Licensed Embalmer No. 4255

P. O. Address. J. C. Mo

**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.**