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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 4326

NOV 1, 1943  
Registration District No. 149

Primary Registration District No. 1002

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:  
4026 East 67th Terrace, 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
In this community 20 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Albert G. Peters  
3. (b) If veteran, name war World War #1  
3. (c) Social Security No. no.

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Grace B. Peters,  
6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased January 26 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 8 24 13 hr. min.

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

10. Usual occupation Contractor

11. Industry or business X  
12. Name Unknown,  
13. Birthplace Scotland,  
(City, town, or county) (State or foreign country)  
14. Maiden name Chapman,  
15. Birthplace Canada  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Grace B. Peters,  
(b) Address 4026 E. 67th Ter., K. C., Mo.

17. (a) removal (b) Date thereof 10-11-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Toledo, Ohio,

18. (a) Signature of funeral director Stine & McClure,  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 10-11-43 (b) T. C. 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. 4026 East 67th Terrace,  
(If rural, give location)  
(e) Citizen of foreign country? X (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 9. 1943  
year 1943 hour 11 minute 30 a. M.  
21. I hereby certify that I attended the deceased from June 30, 1943 to Oct 9, 1943  
that I last saw him alive on Oct 8, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart Disease.  
Due to \_\_\_\_\_  
Due to g4a  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no

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)  
(b) Manner of injury \_\_\_\_\_  
23. Signature George C. Bee (M.D. or other)  
Address 1630 Prof. Bldg. Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

*Orphan*

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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.....

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.**