

S. No. 2
M-9-4-41
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33909

State File No.

4488

Registrar's No.

FILED NOV 1 1943/49
Registration District No.

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:
R.C. TB Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 m 9 d.
(Specify whether years, months or days) 26 yrs

3. (a) PRINT FULL NAME

William Peterson

3. (b) If veteran, name war no

3. (c) Social Security No. 496-09-0616

4. Sex M 5. Color or race C
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years 22 1917 (Year)

7. Birth date of deceased: 2 (Month) 22 (Day) 1917 (Year)

8. AGE: Years 26 Months 7 Days 27 If less than one day hr. min.

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

10. Usual occupation builder

11. Industry or business building

12. Name J. W. Peterson

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

14. Maiden name Sarah Thomas

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

16. (a) Informant: Reeds K.C. TB Hosp
(b) Address Reeds Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26-43 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Just, Appleton & Jones
(b) Address 1905 Vine St
19. (a) 10-22-43 (Date received local registrar) (b) H. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸
(c) City or town Kansas City ³
(If outside city or town limits, write "RURAL") ⁸
(d) Street No. 618 Troost (If rural, give location)
(e) Citizen of foreign country? no (Yes or) No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19
year 1943 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8-10-43
1943, to 10-19- 1943
that I last saw him alive on 10-19 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 4 1/2 yrs

Due to

Due to 135'

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Pul. TB
T.B. extent

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 Matthew J. Hoan (M. D. or other)
Address Reeds Mo. Date signed 10/22/43

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 C. H. West
Licensed Embalmer No. 2710
P. O. Address 150 E. 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.