. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10063

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1539

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:
1234 Agnes Ave. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1234 Agnes Ave.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Charles Edmond Peters

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 3 (Day) 1930 (Year)

8. AGE: Years 13 Months 9 Days 3 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation child

11. Industry or business

FATHER
12. Name Clarence B. Peters
13. Birthplace Gashland (City, town, or county) Missouri (State or foreign country) 0

MOTHER
14. Maiden name Lorine M. Smith
15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant Mrs. Lorine Peters
(b) Address 1234 Agnes

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. F. Pomeroy
(b) Address 3256 Broadway

19. (a) 4-7-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6th.
year 1944 hour 6 minute 35 P.M.

21. I hereby certify that I attended the deceased from Jan 1- 1944, 19, to Apr 6, 1944;
that I last saw him alive on April 5, 1944;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	3-da
Due to Tuberculosis Spine	10 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 16

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

23. Signature F. B. Wallace (M. D. ~~or other~~)
Address 703 Lathrop Bldg Date signed 4/7/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. Frank B. Wallace
Lathrop Bldg.
Har. 7051

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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K 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.