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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JUN 3 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 2290

1. PLACE OF DEATH:  
 (a) County Jackson  
Kansas City  
 (b) City or town  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2919 Paseo /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution XX  
26 years (Specify whether years, months or days)

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")  
2919 Paseo  
 (d) Street No. (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 0

3. (a) PRINT MRS. JOSEPHINE W. PEACHER  
FULL NAME

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

4. Sex Fe 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Andrew J. Peacher  
 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased April 3 1863  
 (Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 24  
 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name William J. Peacher

13. Birthplace Fayette Missouri

14. Maiden name Elizabeth Peacher

15. Birthplace Fayette Missouri

16. (a) Informant Andrew J. Peacher

(b) Address 2919 Paseo

17. (a) Burial (b) Date thereof 5-30-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation Fayette, Mo.

18. (a) Signature of funeral director J. Wagner  
Kansas City, Mo.

(b) Address \_\_\_\_\_

19. (a) 5-27-44 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27  
 year 1944 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from 5-8-44  
 \_\_\_\_\_, 19\_\_\_\_ to 5-27, 19\_\_\_\_  
 that I last saw her alive on 5-25, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arterio-sclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: 97  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_ (Specify type of injury)

23. Signature W. E. Brown (M. D. or other) \_\_\_\_\_

Address 203 North Main Date signed 5-27-44

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

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

MOTHER FATHER

V.A. 6400  
With name by

**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.....

*Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address. *Kansas City, 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.**