DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 14 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24929

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 163

1. PLACE OF DEATH:

(a) County: Jasper

(b) City or town: Carthage (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1725 South Maple St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

In this community 90 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jasper 49

(c) City or town: Carthage 1 (If outside city or town limits, write "RURAL")

(d) Street No.: 1725 So. Maple 3 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Martha E. Peterson

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: female 1

5. Color or race: white

6. (a) Single, widowed, married, divorced: widowed 2

6. (b) Name of husband or wife: Tolbert Peterson

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

7. Birth date of deceased: February (Month) 11 (Day), 1854 (Year)

8. AGE:

Years	Months	Days	If less than one day
90	5	10	hr. min.

9. Birthplace: Bowers Mill (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: at home

11. Industry or business: — — —

MOTHER FATHER

12. Name: George F. Bowers

13. Birthplace: Cincinatti (City, town, or county) Ohio (State or foreign country)

14. Maiden name: Frances Elmore

15. Birthplace: Unknown (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Ethel Peterson

(b) Address: 1725 So Maple - Carthage, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 23 1944 (Month) (Day) (Year)

(c) Place: burial or cremation: Paradise Cemetery

18. (a) Signature of funeral director: Knell Mortuary

(b) Address: Carthage, Missouri

19. (a) July 22 '44 (Date received local registrar) (b) Elizabeth Couplin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1944 hour 11:55 minute P.M.

21. I hereby certify that I attended the deceased from Oct, 1942, to 7-24, 1944, that I last saw h. alive on July 13, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	3 da
Due to: Fracture at hip - 1	2½ mo
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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: 0

23. Signature: D. Russell Smith (M. D. or other) MD

Address: Carthage, Mo Date signed: 7-22-44

(Licensed Embalmer's Statement on Reverse Side)

44-7-611

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.....Emma L. Snell

Licensed Embalmer No.....391

P. O. Address.....Carthage

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 1631

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Martha E. Peterson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. (Month) 11 (Day) 1854 (Year)

8. AGE: Years 90 Months 5 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia — Duration 5 da

Due to Fracture rt. hip 2/2 Mo Intertrochanteric

Due to

Other conditions
(Include pregnancy within 3 months of death)

186a

Major findings:
Of operations

Of autopsy

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) accident

(b) Date of occurrence May 16, 1944

(c) Where did injury occur? Home - Carthage Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? No (e) Means of injury Fall

23. Signature [signature] (M. D. or other) MD

Address Date signed

SUPPLEMENTARY

24929