

FILED MAR 29 1948

Registration District No. **120**Primary Registration District No. **5444**Registrar's No. **20**

1. PLACE OF DEATH:

- (a) County **Gentry**
 (b) City or town **Rural Athens Township**
 (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

3. (a) PRINT FULL NAME **Jessie Belle Peery**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**6. (b) Name of husband or wife **Hurley Peery** 6. (c) Age of husband or wife if alive **80** years7. Birth date of deceased **Oct. 2 1869**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
78 5 10 hr. min.9. Birthplace **Gentry Co. Mo.**
(City, town, or county) (State or foreign country)10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER
 12. Name **Morris T. Chipps**
 13. Birthplace **New Jersey**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Ann Magee**
 15. Birthplace **Unk. Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Union Shull**(b) Address **St. Joseph - Mo**17. (a) **Burial** (b) Date thereof **3/14/48**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Foster New Hampton**18. (a) Signature of funeral director **Walter D. DeBater**(b) Address **W. Albany Mo****March 19 1948** (Date received local registrar) **Walter D. DeBater** (Registrar's signature) **103**

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **Gentry**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **12**
year **1948** hour **One** minute **10 a.m.**21. I hereby certify that I attended the deceased from **January 9**, 1945, to **March 8**, 1948, that I last saw her alive on **March 8**, 1948, and that death occurred on the date and hour stated above.Immediate cause of death **Old age** Duration **2 months**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **16**

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) (e) Means of injury **6**23. Signature **O. F. Sullivan** (M. D. or other) _____Address **Albany Mo** Date signed **3-12-48**

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

1-1-1948

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTAL INFORMATION

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Robert Burns

.....
Licensed Embalmer No.....

3329

P. O. Address.....

Albany 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, above space should be left blank.

Registration District No. 120

Primary Registration District No. 5444

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Rural
(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)

3. (a) PRINT FULL NAME

Jessie B. Peery

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 _____

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

7. Birth date of deceased Oct 2 1881
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days _____ (Unless than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 12
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

S-8402-1948