

No. 2
1/47
7-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11921

National Office of Vital Statistics
FILED MAY 14 1948

Registration District No. _____

Primary Registration District No. 3016

Registrar's No. 112

1. PLACE OF DEATH:

(a) County Cole

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

(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location) 1 day

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

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26

(c) City or town Jefferson City 5
(If outside city or town limits, write "RURAL") 4

(d) Street No. 624 E. High St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary Louise Peterson

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 1948 hour 1:45 minute _____ P.M.

21. I hereby certify that I attended the deceased from Feb. 17
_____, 1948 to May 3, 1948
that I last saw her alive on May 3, 1948
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race White

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

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

7. Birth date of deceased July 10 1880
(Month) (Day) (Year)

Immediate cause of death Lymphosarcoma

Duration _____

Due to _____

Due to _____

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

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>9</u>	<u>23</u>	_____ hr. _____ min.

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

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL INFORMATION REQUESTED

10. Usual occupation Accountant

11. Industry or business _____

12. Name Thomas Day

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

14. Maiden name Unknown

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

16. (a) Informant H.T. Sumrall

(b) Address #16. Alabama

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-48
(Month) (Day) (Year)

(c) Place: burial or cremation Riverview Cemetery

18. (a) Signature of funeral director Victor Busch

(b) Address Jefferson City, Mo

19. (a) 5-3-48 (Date received local registrar) (b) R.O. Harris (Registrar's signature)

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? _____ (a) Means of injury 0

23. Signature Earl J. Boyd (M. D. or other) _____

Address 425 Madison Date signed 5/2/48

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

MOTHER FATHER

Jeff. City, Mo

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed

JAN 4 1949

MAY 13 1948

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 Victor Buescher

Licensed-Embalmer No. 3701

P. O. Address Jefferson City

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. mayRegistration District No. 77Primary Registration District No. 3014Registrar's No. 112

1. PLACE OF DEATH:

(a) County Colo
(b) City or town Jefferson City
(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 _____ (Specify whether _____)
years, months or days3. (a) PRINT FULL NAME May J. 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 wid

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

7. Birth date of deceased July 10 (Month) (Day) (Year)8. AGE: Years 67 Months 9 Days 3 (If less than one day, hr. min.)9. Birthplace Spain (City, town, or county) (State or foreign country)

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 _____ year 1944 hour _____ minute _____ M. 321. I hereby certify that I attended the deceased from _____ to _____, 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 not known - she had a lymphallastoma - Hodgkins
Due to type involving the entire reticulo-endothelial system -
Other conditions liver, spleen, lymph nodes
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 Carl P. Loyd, M.D. (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-11921