

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27011
3570

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 3570	
1. PLACE OF DEATH a..COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a..STATE MISSOURI b..COUNTY JACKSON			
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		c. LENGTH OF STAY (in this place) 4 yrs		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		35	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSPITAL				d. STREET ADDRESS (If rural, give location) 2728 CYPRESS AVENUE			
3. NAME OF DECEASED (Type or Print) a. (First) JUDY b. (Middle) LOUISE c. (Last) PETERMAN			4. DATE OF DEATH (Month) (Day) (Year) AUG. 17-1949				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH July 20, 1943		9. AGE (In years last birthday) 6	if UNDER 1 YEAR Months Days	if UNDER 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KANSAS CITY Mo D		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME LAURENCE D. PETERMAN		13b. MOTHER'S MAIDEN NAME HARRIETTE TIMBERLAKE		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or known) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Laurence Peterman K.C. Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) (b) (c) MEDICAL CERTIFICATION (a) Uremia (b) Ascending Pyelonephritis Acute Chronic (c) Congenital Spina Bifida + Hydrocephalus DUE TO (a) (b) (c) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congenital Deficiency Rt Hip 751X					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Russell W. Kerr (Degree or title)				23b. ADDRESS St. Joseph's Hospital		23c. DATE SIGNED 17 Aug 49	
24a. BURIAL: CREMATION REMOVAL (Specify) Burial		24b. DATE Aug. 19, 1949		24c. NAME OF CEMETERY OR CREMATORIUM Flora H. Hills		24d. LOCATION (City, town, or county) (State) Kansas City Mo.	
DATE REC'D BY LOCAL REG. 8-18-49		REGISTRAR'S SIGNATURE Deraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. H. Newcomers Sons, K.C., Mo			

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Bernard L. Horan* _____

Licensed Embalmer No. *4250* _____

P. O. Address *N. 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.