

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37508

State File No. ....

5082

FILED DEC 15 1951

BIRTH NO. .... REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. ....

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	c. LENGTH OF STAY (In this place) <b>18 yrs.</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Research Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>7121 Summit</b>	

*3928*

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) <b>EMMA</b>	b. (Middle)	c. (Last) <b>PETERSON</b>	<b>Nov. 25, 1951</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 23, 1860</b>	9. AGE (In years last birthday) <b>90</b>	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) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Gustave Erickson</b>	13b. MOTHER'S MAIDEN NAME <b>-</b>	14. NAME OF HUSBAND OR WIFE <b>John Peterson</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mr. C. J. Carlson, 7121 Summit, K.C. Mo.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Congestive Heart Failure</b>		DUE TO (b) <b>Arterio-sclerotic Heart Disease</b>		<b>12 hours</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <b>Arterio-sclerosis</b>		<b>4250</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic Congestive Failure, Senility</b>				<b>2 yrs.</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 26, 1949, to Nov. 25, 1951, that I last saw the deceased alive on Nov 25, 1951, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Carl R. Ferris M.D.</b>	23b. ADDRESS <b>934 Argyle Blvd Kansas City, Mo</b>	23c. DATE SIGNED <b>Nov. 26 1951</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11/26/51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>-</b>	24d. LOCATION (City, town, or county) (State) <b>Indianola, Iowa</b>
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DATE REC'D BY LOCAL REG. <b>11-27-51</b>	REGISTRAR'S SIGNATURE <b>Stualling Holmes</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>STINE &amp; McCLURE, Kansas City, Missouri</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

"Mrs Fernis Layton - Austin  
Angeles Bldg. - Uic 8227  
Amount \$: 0 0

**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.....

.....  
working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. ....  
Signed *Eugene Thompson* .....  
Licensed Embalmer No. *4633* .....  
P. O. Address *Kenosha City Wisc* .....

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.