

FILED APR 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH13338  
STATE FILE NUMBER  
1529

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1529

S. 300  
1-57

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, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hosp</b>			Length of stay in 1b <b>36 Years</b>		d. STREET ADDRESS <b>3326 Prospect</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Cashious M. PETTIJOHN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1957</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 16, 1896</b>		9. AGE (In years last birthday) <b>61</b>		FUNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Power &amp; Light Co.</b>		11. BIRTHPLACE (City and state or country) <b>Furnas Co. Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>Cashious M. Pettijohn</b>			13b. MOTHER'S MAIDEN NAME <b>Fannie Hall</b>			14. NAME OF HUSBAND OR WIFE <b>Emma M. Pettijohn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>195-03-2249</b>		17. INFORMANT Address <b>Emma M. Pettijohn 3326 Prospect K.C. Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Peritonitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Perforated Peptic Ulcer</b>							<b>15 days</b>		
DUE TO (c) _____							<b>5401</b>		
PART II. - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <b>Mar-13-57</b> to <b>Mar-30-57</b> and last saw <sup>her</sup> him alive on <b>Mar-30-57</b> Death occurred at <b>11:55</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Carl H. Brust</b> (Degree or title)					22b. ADDRESS <b>106 W 14th St K.C. Mo</b>			22c. DATE SIGNED <b>Mar-31-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-1-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>			23d. LOCATION (City, town, or county) (State) <b>Okla. City Okla.</b>			
24. FUNERAL DIRECTOR <b>Mellody McGilley Eylar Kan. City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>4-1-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Carl H. Brust



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 .....  
Signature of Student Embalmer

Signed *James E. Kachilema*

Licensed Embalmer No. *4533*

P. O. Address *K.P., MD*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.