

FILED DEC 3 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40932**

BIRTH NO. _____ REG. DIST. NO. 165 PRIMARY REG. DIST. NO. 5610 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>	
b. CITY OR TOWN <u>Rural, Jefferson</u>	c. LENGTH OF STAY (in this place township) <u>3 years</u>	c. CITY OR TOWN <u>15 miles S.E. Warrensburg, Mo.</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		STREET ADDRESS (If rural, give location) <u>RM. # 2 - Lorton Mo</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>OLAF</u> b. (Middle) <u>HASKEL</u> c. (Last) <u>PETREE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23 1957</u>
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 13 - 1906</u> 9. AGE (In years last birthday) <u>51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) <u>Richmond, Mo.</u>
12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A</u>	

13a. FATHER'S NAME <u>Fred Petree</u>	13b. MOTHER'S MAIDEN NAME <u>Lillian Rose</u>	14. NAME OF HUSBAND OR WIFE <u>Loretta Petree</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>487-07-0636</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Loretta Petree, Lector, Mo</u>	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>14 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Kidney</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>180X</u>
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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? _____
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22. I hereby certify that I attended the deceased from July, 1956, to 11-23, 1957, that I last saw the deceased alive on 11-2, 1957, and that death occurred at 11 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. Lee Cooper M.D.</u> (Degree or title) <input checked="" type="checkbox"/>	23b. ADDRESS <u>Warrensburg Mo</u>	23c. DATE SIGNED <u>11/23/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11-23-1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson</u>	24d. LOCATION (City, town, or county) (State) <u>Lawson, Mo</u>
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DATE REC'D BY LOCAL REG. <u>11/27/57</u>	REGISTRAR'S SIGNATURE <u>Jucod</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jarman Prichard, Lawson, Mo</u>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

516-0

DEC 4 1957

DEC 17 1957

APR 30 1958

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 Lindell Jarman
Licensed Embalmer No. 4589
P. O. Address Excelsior Springs 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.