

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-040930**

**FILED VS NOV 17 1959**

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 182

ENDED

1. PLACE OF DEATH a. COUNTY <u>MACON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON</u>		Length of stay in 1b <u>2 Wks</u>		c. CITY OR TOWN <u>CLARENCE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAMARITAN HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>CLARENCE MO</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH EMMA PETERMAN</u>				4. DATE OF DEATH Month Day Year <u>OCT 10 1959</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 4 1884</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (City and state or country) <u>SHELBY COUNTY MO US</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13a. FATHER'S NAME <u>JOHN GIBBEN WHILES</u>			13b. MOTHER'S MAIDEN NAME <u>JANE PAINEY</u>		14. NAME OF HUSBAND OR WIFE <u>L. J. PETERMAN</u>			
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>NONE</u>		17. INFORMANT Address <u>MRS DEE PETERMAN CLARENCE MO</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral vascular accident</u>							<u>10 days</u>	
DUE TO (c) <u>arteriosclerosis</u>							<u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 a.m. p.m.	Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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 <u>5-30-1953</u> to <u>10-10-1959</u> and last saw her alive on <u>10-10-1959</u> Death occurred at <u>11:00</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Neal R. Hull D.O.</u>				22b. ADDRESS <u>Clarence, Mo</u>			22c. DATE SIGNED <u>10-19-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MARLEWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>			
24. FUNERAL DIRECTOR <u>GREENING</u>			ADDRESS <u>CLARENCE MO</u>		25. DATE RECD. BY LOCAL REG. <u>11/17/59</u>		26. REGISTRAR'S SIGNATURE <u>Will M. Sweeney</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Charles V. Greening*

Licensed Embalmer No. 4625

P. O. Address Lawrence

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.