

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5606 -51-041209
STATE FILE NUMBER

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

AMENDED

FILED DEC 1 1961

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, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 8 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1240 W. 70th Terrace		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1240 W. 70th Terrace Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First James , Middle Aloysius , Last Peters			4. DATE OF DEATH Month November , Day 8 , Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1875	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Med. Doctor & Surgeon		10b. KIND OF BUSINESS OR INDUSTRY Medical	11. BIRTHPLACE (City and state or country) Solon, Iowa	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John S. Peters		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Agnes G. Peters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Dr. Urban R. Peters, 1240 W. 70th Terr. Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)	Arteriosclerotic cerebrovascular disease	INTERVAL BETWEEN ONSET AND DEATH 10 years
DUE TO (b)	& cerebral thrombosis	1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

congestive heart failure

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **October 1960** to **Nov 1961** and last saw ^{her} _{him} alive on **12/15/1960**
Death occurred at **unknown** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Warren F. Wilhelm, M.D. (Degree or title)	22b. ADDRESS Prof. Bldg., Kansas City, Mo	22c. DATE SIGNED 11/8/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial	23b. DATE 11-9-61	23c. NAME OF CEMETERY OR CREMATORY -
23d. LOCATION (City, town, or county) Oxford Iowa		(State)

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home ADDRESS 20 west Linwood	25. DATE RECD. BY LOCAL REG. 11-8-61	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF
Warren F. Wilhelm, M.D.

ITEM NO. SHOULD READ

Dr. Wilhelm

Ba 1-5155

Prof. Blodgett

12 noon -

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 Huyd F. Dickman

Licensed Embalmer No. 5120

P. O. Address K. E. 9, 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.