

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

D. B. Groeman
NOV 18 1938

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

35555
Do not use this space.

1. PLACE OF DEATH *Deer 2*

(a) County *Deer* Registration District No. *266*
 (b) Township *Nalmer* Primary Registration District No. *4164*
 (c) City *Nalmer* (d) Street No. _____ Registered No. *71*
 (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME *Charley George Peers*

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Chel Peers*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 6 - 1886*

7. AGE YEARS *52* MONTHS *9* DAYS *18* If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Wholesale Gro.*
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Deer Co Mo*

FATHER 13. NAME *George W Peers*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

MOTHER 15. MAIDEN NAME *Rhoda Ray*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Deer Co Mo*

17. INFORMANT (ADDRESS) *M. Charley Peers Nalmer Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Deer Groves* DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) *Carl H. Peers Nalmer Mo*

20. FILED *Oct 28 1938* *F. E. Butler M.D.* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *October 28 1938*

22. I HEREBY CERTIFY, That I attended deceased from *October 26 1938* to *October 28 1938*
 I last saw him alive on *October 28 1938*. Death is said to have occurred on the date stated above, at *2:20 a.m.*
 The principal cause of death and related causes of importance were as follows:
Hypertension, essential

Date of onset *March 1938*

Other contributory causes of importance:
Chronic myocarditis

Name of operation *none* Date of _____
 What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*
 If so, specify _____ (Signed) *Maurin Groeman!* M. D.
 (Address) *240 Salem, Mo.*

STATEMENT BY LICENSED EMBALMER

I, Carl K. Spencer, Licensed Embalmer No. 2370

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Myself

L. E.

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed Carl K. Spencer

Licensed Embalmer No. 2370

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.)

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35-584
Do not use this space.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

(a) County Scott Registration District No. 266
(b) Township Salem Primary Registration District No. 4164 Registered No. 71
(c) City Salem (d) Street No. _____
(e) Length of residence in city or town where death occurred _____
yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) _____
(f) How long in U. S., if of foreign birth? _____
yrs. mos. ds.

2. PRINT FULL NAME

Charley George Pines (9)
(a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
52 9 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE October 30 1938

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED October 28 1938 F. E. Butler Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 28 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.
I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Mary Brown, M. D.
(Address) Salem

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-3555.5