

N. E.—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.

1939 APR 12 1939

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

791  
1008

9176  
Do not use this space.

2941

1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) City or Town St. Louis (d) Street No. St. Anthony's Hosp. St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Helen Peters

(a) Residence, No. 2821 Miami St. St. 24 (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 Female 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 Walter Peters

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 7, 1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
34 1 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Housewife  
 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) St. Louis

FATHER 13. NAME Ernest Halamicek

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

MOTHER 15. MAIDEN NAME Anna Pavlick

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

17. INFORMANT (ADDRESS) Walter Peters  
2821 Miami St.

18. BURIAL, CREMATION, OR REMOVAL PLACE N. St. Marcus DATE Mar. 30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wacker-Helderle  
2331 S. Broadway

20. FILED MAR 29 1939 J. D. Brudner Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 27, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1938 to March 27, 1939  
 I last saw him alive on March 27, 1939. Death is said to have occurred on the date stated above, at 8:30 p.m.  
 The principal cause of death and related causes of importance were as follows:

Acute Staphylococci Septicemia  
Chronic Rheumatism  
 Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... 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?.....  
 If so, specify (Signed) Wacker-Helderle M. D.  
 (Address) 3600 S. Grand Blvd.

**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.....

*Robert Wheeler*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Robert Wheeler*

Licensed Embalmer No. ....

*2178*

P. O. Address.....

*St. Louis, 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 this body is not embalmed, above space should be left blank.**