

REC'D AUG 11 1939

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

25023

Do not use this space.

## 1. PLACE OF DEATH

(a) County Buchanan / Registration District No. 85  
 (b) Township / Primary Registration District No. 1001 Registered No. 683  
 (c) City St. Joseph (d) Street No. Mo. Methodist Hospital 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. 3 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

362 Mrs. Elsie Mattie Peters  
 (a) Residence, No. 1012 Luella Ave Savannah Mo.  Savannah Mo.  
 (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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-3-1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
37 8 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 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) Rea Mo

FATHER 13. NAME Orba E. Peters

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Preble Co. Ohio

MOTHER 15. MAIDEN NAME Leora W. Walker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson O. Ohio

17. INFORMANT O. E. Peters  
 (ADDRESS) Savannah Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Bolckow Mo DATE 7-7-1939

19. FUNERAL DIRECTOR Fred Terhune  
 (ADDRESS) Savannah Mo

20. FILED July 6, 1939 H. J. Nestlebrush  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 4, 193922. I HEREBY CERTIFY, That I attended deceased from July 1, 1939, to July 4, 1939I last saw her alive on July 4, 1939. Death is said to have occurred on the date stated above, at 8 p. m.

The principal cause of death and related causes of importance were as follows:

Fibroid tumors of the uterus. Date of onset 3.  
54 lb

Other contributory causes of importance:

Shock following operation.

Name of operation Hyster. appendectomy Date of 7/5/39  
 What test confirmed diagnosis Lab. Clin. Gps. 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

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) W. J. Deam, M. D.  
 (Address) St. Joseph, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

BOM-7-20-37 I 121004

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.

STATEMENT BY LICENSED EMBALMER

I, J. Friederichs, Licensed Embalmer No. 1279

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

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed J. Friederichs  
Licensed Embalmer No. 1279

**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.)**