

1937 DEC 13 5
Registration District No. 5

Primary Registration District No. 3010

Registrar's No. 133

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(c) Name of hospital or institution:
203 So Virginia
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Entire life (Specify whether years, months or days)

8. (a) PRINT FULL NAME Cora B. Peltier
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Galbert Peltier 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 7, 1859
(Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 25 If less than one day hr _____ min _____

9. Birthplace Carroll Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation at Home

11. Industry or business _____

MOTHER FATHER
12. Name Oscar B. Zuehl
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Sarah A. Scott
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edwin Peltier
(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 11-4-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Mary's Cem

18. (a) Signature of funeral director Walter Stansley
(b) Address Carrollton Mo

19. (a) 11-3-39 (b) Walter Stansley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2 year 1939 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2-22-39 to 11-2-39 that I last saw her alive on 11-2-39 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 3 days

Due to _____
Due to _____

Other condition Fracture right femur 2/2/39
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
(e) Means of injury _____

23. Signature W.G. Atwood (M. D. or other) _____
Address Carrollton Mo Date signed 11/3/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

12/14/39

2 Bunde

JUL 15 1955

RECEIVED
District Health Officer No. 8,
District File Number
12/16/39
Filed

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Ben W. Gibson
Licensed Embalmer No. 2961
P. O. Address Carrollton, W

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

39248
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
(b) Township Carrollton Primary Registration District No. 3010 Registered No. 103
(c) City..... (d) Street No..... 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 Cora B. Peltier

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
79 11 25

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 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 2 1939

22. I HEREBY CERTIFY, That I attended deceased from to, 19.....

I last saw h..... alive on, 19..... Death is said to have occurred on the at, m.
The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia Date of onset 11/23/39
Developed due to being bed fast with fractured hip.
Fracture right femur
due to fall, 2/22/39

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) W. J. Atwood M. D.
(Address) Carrollton Mo

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SUPPLEMENT

