

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

14555
Do not use this space.

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.

1. PLACE OF DEATH

(a) County Carter Registration District No. 145
 (b) Township Johansen Primary Registration District No. 5208 Registered No. 5
 (c) City 2 (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

(a) Residence, No. 201 ELMORE PEEK St. HUNTER, Mo. 0
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Haniel Elizabeth Peck
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 5 28

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28, 1940
 22. I HEREBY CERTIFY, That I attended deceased from March 7, 1940, to April 28, 1940
 I last saw h. in alive on April 24, 1940 Death is said to have occurred on the date above, at 4:30 P.M.
 The principal cause of death and related causes of importance were as follows:

OCCUPATION 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. Farmer
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 42

Hodgkins Disease
 Date of onset _____
 Other contributory causes of importance: 72 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dillard, Mo.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? NO

FATHER 13. NAME Zachariah Jackson Peck
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

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.

MOTHER 15. MAIDEN NAME Haniel Elizabeth Turnbull
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

Manner of injury _____
 Nature of injury _____

17. INFORMANT (ADDRESS) Ralph Peck
Hunter, Mo.

24. Was disease or injury in any way related to occupation of deceased? NO
 If so, specify _____ (Signed) T. W. Cotton, M. D.
 Address Van Buren, Mo.
by T. B. Buchstape

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Ten Mile Cemetery DATE April 29, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) _____

20. FILED 4-29, 1940 Loyal B. Wood
Local Registrar.

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 540.534

Licensed Embalmer No.....

Date Filed 5/10/40

P. O. Address.....

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.

Registration District No. 145

Primary Registration District No. 5208

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carter
(b) City or town Jackson
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Elmore Peck

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased Nov 28 1879
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 28 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-5-1940 (b) Loyal E. Hood
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 apr day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____
PHYSICIAN _____
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? _____

While at work _____ (Specify type of place)
(Means of injury)

23. Signature G. W. Cotton (M. D. or other) _____

Address Van Buren Date signed _____

SUPPLEMENTAL

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

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