

**DEAD** AUG 19 1940  
Registration District No. **23**

Primary Registration District No. **5124**

Registrar's No.

**1. PLACE OF DEATH:**

(a) County **Buchanan**  
(b) City or town **Wallace** No. **1**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **None**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **None**  
In this community **Fifty Years** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Buchanan**  
(c) City or town **Wallace, Missouri**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **None** (If rural, give location)  
(e) If foreign born, how long in U. S. A. **all his life** years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **July** day **23rd**  
year **1940** hour **7** minute **50** P. M.  
21. I hereby certify that I attended the deceased from **July 23**  
**1940**, to **July 29**, **1940**;  
that I last saw him alive on **July 23**, **1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Cerebral Hemorrhage**  
Due to **arterio-sclerosis**  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
**82W**

Duration  
PHYSICIAN  
Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

3. (a) PRINT FULL NAME

**Irvin R. Peter + 360**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Effa A. Peter**

6. (c) Age of husband or wife if alive **18** years

7. Birth date of deceased **March 18 1864**  
(Month) (Day) (Year)

8. AGE: Years **76** Months **4** Days **5**  
If less than one day hr. min.

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

10. Usual occupation **Physician, N.D.**

11. Industry or business **None**

12. Name **Lemuel Peter**

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

14. Maiden name **Sarah E. Reed**  
15. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Effa A. Peter**

(b) Address **Wallace, Missouri**

17. (a) **Burial** (b) Date thereof **July 25th**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **DeKalb, Missouri**

18. (a) Signature of funeral director **Lucian Davis**

(b) Address **Dearborn Missouri**

19. (a) **7/24/1940** (b) **M. S. Hull**  
(Date received local registrar) (Registrar's signature)

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?  
**83** (Specify type of place)  
While at work? (e) Means of injury

23. Signature **A. Monroe Peter** (M. D. or other)  
Address **Whiteville Mo** Date signed **8/22**

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

RECEIVED

District Health Officer No. 11,

District File Number 840-1265

Date Filed AUG 13 1940

*L.B. W. W. W.*

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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Russell Davis

Licensed Embalmer No. 4169

P. O. Address Deerborn 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.