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BUREAU OF THE CENSUS

State File No. \_\_\_\_\_

7103

Registration District No. **791-1**

Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital, #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 Days  
(Specify whether In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis 23  
(If outside city or town limits, write "RURAL")

(d) Street No. 2721<sup>9</sup> Missouri Av.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Horace Peters 362

3. (b) If veteran, name war none

3. (c) Social Security No. none

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 21, year 1940 hour 7:00 minute \_\_\_\_\_ P. M.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife Susanna Peters 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Mar. 24 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 28, 1940 to August 21, 1940; that I last saw him alive on August 21, 1940; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>4</u>	<u>27</u>	hr. _____ min. _____

Immediate cause of death: Incarcerated Inguinal Hernia

Due to: Arteriosclerosis  
Bronchopneumonia

Due to: \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death): \_\_\_\_\_

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

10. Usual occupation Retired Time Keeper

Major findings: Incarcerated Inguinal Hernia  
Arteriosclerosis + Bronchopneumonia

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name Frank Peters

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

14. Maiden name Catherine Miller

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

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? \_\_\_\_\_

16. (a) Informant Susanna Peters

(b) Address 2721<sup>9</sup> Missouri Av

17. (a) Burial (b) Date thereof 8-24-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marcus Cem.

18. (a) Signature of funeral director With Bro. L. & G. Co

(b) Address 2929 S. Jefferson Av

19. (a) AUG 23 1940 (b) J. A. [Signature]  
(Date received local registrar) (Registrar's Signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature L. N. Mulligan (M. D. or \_\_\_\_\_)

Address 1515 Lafayette Ave. Date signed 8/22/40

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

**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 \_\_\_\_\_

*Paul R. Shanklin*

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

working under my personal supervision.

Signed \_\_\_\_\_

*Paul R. Shanklin*

Licensed Embalmer No. 3472

P. O. Address 29298 Jeff

**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.**