

No. 2
-10-39
7-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10:10-AM.
31890
State File No.

Registration District No. 266

Primary Registration District No. 5376

Registrar's No. 67

1. PLACE OF DEATH:

(a) County DeWitt

(b) City or town Rural ~~DeWitt~~ Norman Township
(If outside city or town limits, write "RURAL" and name of township)

(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 2
(Specify whether years, months or days)

In this community 74 years.
years, months or days

8. (a) PRINT FULL NAME Columbus C. Peck.

8. (b) If veteran, name war No.

3. (c) Social Security No. _____

4. Sex M.

5. Color or race W.

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years
(Day) (Year)

7. Birth date of deceased 7 23 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

75 2 7 _____ hr. _____ min.

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

10. Usual occupation Farmer.

11. Industry or business _____

12. Name Thomas Peck.

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

14. Maiden name Sarah Hannah

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

16. (a) Informant Opal Peck.

(b) Address Salem, Mo.

17. (a) Burial. (b) Date thereof 10 1 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove

18. (a) Signature of funeral director Robt. H. Shanthan

(b) Address Salem, Mo.

19. (a) Oct 1 1940 (b) F. E. Smith M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County DeWitt

(c) City or town Norman Township, Rural
(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 Sep 30 day 30
year 1940 hour 10 A minute A M.

21. I hereby certify that I attended the deceased from Sep 27 to Sep 30, 1940
that I last saw him alive on Sep 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Neuremia
R & L
Due to Stroke Old

Due to _____

Other conditions ✓ 100
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: ✓

Of operations _____

Of autopsy No

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

(a) Accident, suicide, or homicide (specify) NO

(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?
240 (Specify type of place) _____
While at work (e) Means of injury ✓

23. Signature W. J. Dillan (M. D. or other) M.D.
Address Salem Mo Date signed Sep 30 1940

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

RECEIVED

District Health Officer No. 5,

District File Number... 10401007

Date 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.....

N. D. Holson

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *N. D. Holson*

Licensed Embalmer No. *924*

P. O. Address. *Salem ME*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.