

No. 2  
4-13-40  
5-17-39

Dr. Williams

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28281  
Registrar's No. 628

FILED AUG 23 1943  
REGISTRATION DISTRICT NO. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH: **GREENE**  
(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution: 874 N. National /  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene 39  
(c) City or town Springfield 6  
(If outside city or town limits, write "RURAL")  
(d) Street No. 874 N. National  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mary A. Peek  
(b) If veteran, name war no  
(c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug. day 4  
year 1943 hour 11 minute 35 p. M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife James A. Peek  
6. (c) Age of husband or wife if alive unk. year 1851  
7. Birth date of deceased. March 4 1851  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from off and on  
for 10 years, 1933, to 1943  
that I last saw her alive on July 25  
and that death occurred on the date and hour stated above, 1943.

8. AGE: Years 92 Months 5 Days 0  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Senility and Chronic Arthritis  
Duration 20 yrs

9. Birthplace unk. Ohio /  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions None  
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Of operations None  
Of autopsy None

MOTHER FATHER { 12. Name Simon P. Young  
13. Birthplace unk. Ohio /  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Wessman  
15. Birthplace unk. Ohio /  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Lelah Vaneerford  
(b) Address Springfield, Mo.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Aug. 7, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation National Cem.

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) (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director H.H. Lohmeyer  
(b) Address Springfield, Mo.  
19. (a) 8-6-43 (b) D. W. Handley  
(Date received local registrar) (Registrar's signature)

23. Signature Robert Keenan (M.D. or other)  
Address Springfield mo Date signed 8/6/43

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(Licensed Embalmer's Statement on Reverse Side)

**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.....

*Walter E Hamilton*

Licensed Embalmer No.....

*3808*

P. O. Address.....

*Springfield Ma*

**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, fact should be so stated above.**