

S. No. 2
DOM-2-43
ev. 5-17-39
I X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19107
Registrar's No. 5002

Registration District No. 318
Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3023 Ohio Av.
(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 William Peche
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, widower
6. (b) Name of husband or wife Suzette Peche
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 2 1857
(Month) (Day) (Year)

8. AGE: Years 88 Months 8 Days 26
If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Unknown Peche

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

14. Maiden name Unknown

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

16. (a) Informant William Peche Jr.
(b) Address 4132 Holly Hills Bldg.

17. (a) Cremation (b) Date thereof 7-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mo. Crematory

18. (a) Signature of funeral director with Bro. & Mc.
(b) Address 2924 S. Jefferson Av.
19. (a) JUN 20 1945 (Date received by Registrar)
J. B. Brudeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3023 Ohio Av.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 28
year 1945 hour 1 minute 50 p. M.
21. I hereby certify that I attended the deceased from April 1
1945, to June 28, 1945.
that I last saw him alive on June 27, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Duration 3 years
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____
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)
(a) Means of injury? _____
23. Signature John Stuart (M. D. or other) _____
Address 2840 California Date signed 6-29-45

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 *Ronald O Spohnke*
Licensed Embalmer No. 3917
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, fact should be so stated above.