

FILED 411-23 1945
Registration District No. 3076

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME Alfred H. Peters

3. (b) If veteran, name war Yes W. War #1.

3. (c) Social Security No. 497-03-359

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Mary

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased August (Month) 1894 (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>11</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation Route Foreman

11. Industry or business Pevely Dairy

12. Name Unknown

13. Birthplace Unknown 0
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Peters

(b) Address 9048 Kathleen

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

(c) Place: burial or cremation Nat'l Cemetery, J. B., Mo.

18. (a) Signature of funeral director Wacker-Heldner

(b) Address 3634 Gravois Ave.

19. (a) 7-19-1945 (b) L. M. Barran M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis?

(c) City or town Affton
(If outside city or town limits, write "RURAL")

(d) Street No. 9048 Kathleen
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
year 1945 hour 11 minute 25 P. M.

21. I hereby certify that I attended the deceased from July 14, 1945 to July 16, 1945
that I last saw him alive on July 16 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Medullary Osteoma

Duration _____

Due to Increased Intracranial pressure

Due to Cyst of Right Frontal lobe of Cerebrum

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations As above 56d

Of autopsy Done

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) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed 7/19/45

OCT - 8 1945

JUL 25 1945

AUG 23 1945

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..... *Frank J. Hand*

Licensed Embalmer No. *2675*

P. O. Address *St. Louis*

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.