

S. No. 2  
M-5-43  
7-5-17-39  
I X38671

FILED DEC 10 1945

STANDARD CERTIFICATE OF DEATH

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

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 171

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Nevada - Rural Wash

(c) Name of hospital or institution: State Hosp No 32

(d) Length of stay: In hospital or institution. 9 yrs 3 mo 21 days

In this community 9 yrs 3 mo 21 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence

(c) City or town Monett

(d) Street No. 304 W. Cleveland

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME WILLIAM-PECK

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex m 5. Color or race wh

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

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive none years

7. Birth date of deceased Oct 14, 1889

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>1</u>	<u>3</u>	<u>-</u> hr. <u>-</u> min.

9. Birthplace mt Vernon Mo

10. Usual occupation f. farmer

11. Industry or business none

12. Name John B. Peck

13. Birthplace unknown Iowa

14. Maiden name Jennie Broderick

15. Birthplace Triffin Ohio

16. (a) Informant Records State Hosp 3

(b) Address Nevada Mo.

17. (a) Removal (b) Date thereof 11-17-45

(c) Place: burial or cremation Bolivar, Mo.

18. (a) Signature of funeral director M. E. Guhinger

(b) Address Nevada Mo.

19. (a) Nov. 19, 1945 (b) Kathryn H. Vance

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17 year 1945 hour 5 minute A M.

21. I hereby certify that I attended the deceased from Oct, 1939, to Nov 17, 1945

that I last saw him alive on Nov 16, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death viewed

Epilepsy remains

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

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

Other conditions With Deterioration

Major findings: Of operations none

Of autopsy none

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) No!

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_

23. Signature Paul L Barone (M. D. or other)

Address State Hosp No 3 Date signed Nov 17,

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

RECEIVED

Division of Health Officer No. 7,

Dist. No. 11-45-1206

Date Filed 12-10-45

**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 *Marsh E. Eicher*.....

Licensed Embalmer No. *2656*.....

P. O. Address *Neada, Mo.*.....

**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.