

No. 2
-12-45
5-17-39
X4702

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43398
State File No. 11140
Registrar's No.

FILED DEC 31 1947

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months
In this community 40 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Peter H Peterson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Jessie G. Peterson
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 29, 1869
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 13
If less than one day _____ hr. _____ min.

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

10. Usual occupation Meat-cutter

11. Industry or business Retired

12. Name Peterson

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

14. Maiden name unknown

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

16. (a) Informant Fluett Peterson

(b) Address 9132 Ashby Rd

17. (c) Burial (b) Date thereof Dec. 6, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland, Overland, Mo.

19. (a) DEC 5-1947 (Date received local registrar)
J. P. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 3132 Ashby Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1947 hour 9 minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Due to Cerebral vessels
Due to Cerebral Liver
Primary site-Liver
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)
(e) Means of injury _____
Signature Oliver A. Hill (M. D. or other)
Address 4912 Maryland Date signed 12-5-47

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

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.