

FILED JUL 3 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5748**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution Barnes Hospital, 0
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 6 days
In this community 6 days
years, months or days

3. (a) PRINT FULL NAME Peltason, Sophia
3. (b) If veteran, name war _____
3. (c) Social Security No. none
4. Sex F. / 5. Color or race W.
6. (a) Single, widowed, married, divorced, wid.
6. (b) Name of husband or wife Leo H. Peltason
6. (c) Age of husband or wife if alive 1870 years
7. Birth date of deceased July 26
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 0
If less than one day hr. _____ min. 0
9. Birthplace St. Charles Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation At home

11. Industry or business _____
12. Name Charles Brown
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Henrietta Schwartz
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edwin D. Warren
(b) Address 901 S. Meramec, Clayton Mo.
17. (a) Burial (b) Date thereof 6/28/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive (Jewish)
18. (a) Signature of funeral director Mayer
(b) Address 4356 Lindell Blvd
19. (a) JUL 27 1948 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Clayton
(If outside city or town limits, write "RURAL.")
(d) Street No. 901 S. Meramec St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 6 day 26
year 1948 hour 4 minute 35 A.M.
21. I hereby certify that I attended the deceased from 6-20
1948, to 6-26, 1948
that I last saw him alive on 6-26, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Heart failure</u>	
Due to <u>Hypertensive cardio-vascular disease 15 yrs.</u>	
<u>Coronary artery disease 15 yrs.</u>	
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)
(e) Means of injury _____
23. Signature James F. Vagge (M.D. or other) MD
Address Barnes Hospital Date signed _____

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..... *John S. Penn*.....
Licensed Embalmer No..... *4194*.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.