

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35465

State File No. 8856

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cole</b>					
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>Jefferson City</b>		d. STREET ADDRESS (If rural, give location) <b>R.R. 712 Washington</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				3. NAME OF DECEASED (Type or Print) a. (First) <b>Ida</b> b. (Middle) <b>S.</b> c. (Last) <b>Peasoner</b>					
4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 13, 1949</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>			
8. DATE OF BIRTH <b>July 10, 1866</b>		9. AGE (In years last birthday) <b>83</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (State or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Peter Johnson</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			
14. NAME OF HUSBAND OR WIFE <b>August Peasoner</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>A.W. Peasoner, Poplar Bluff, Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis with Hypertension</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>Years</b>  <b>331X</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <b>102</b>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H/H/H</b>					
22. I hereby certify that I attended the deceased from <b>3-8, 1947</b> , to <b>10-13, 1949</b> , that I last saw the deceased alive on <b>10-13, 1949</b> , and that death occurred at <b>6:45 p.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Edward A. Westrup, M.D.</b> (Degree or title)		23b. ADDRESS <b>204 E. Big Bend</b>		23c. DATE SIGNED <b>10-14-49</b>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>10-14-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Jefferson City, Mo.</b>					
24d. LOCATION (City, town, or county) (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd</b>							
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>OCT 14 1949</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd</b>							

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed J. Wm. Buckley  
Licensed Embalmer No. 3653

P. O. Address 29 Long Ave

**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.