

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14648**
3630

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO.		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Olney	
		d. STREET ADDRESS (If rural, give location) 502 South Grand avenue	

3. NAME OF DECEASED (Type or Print) a. (First) BETTYE b. (Middle) ARLENE c. (Last) PETERS			4. DATE OF DEATH (Month) (Day) (Year) 4 15 52		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH 1-15-1926		9. AGE (in years last birthday) 26		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Olney, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Claude Herdes		13b. MOTHER'S MAIDEN NAME Minnie Eavens		14. NAME OF HUSBAND OR WIFE Jessie Peters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jessie Peters, Olney, Ill.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRAIN TUMOR * MALIGNANT							
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		DUE TO (b) _____					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 193X			

22. I hereby certify that I attended the deceased from **APR. 2, 1952**, to **APR. 15, 1952**, that I last saw the deceased alive on **APR. 15, 1952**, and that death occurred at **6:55A. m.**, from the causes and on the date stated above.

23a. SIGNATURE F. R. Bradley (Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 4/15/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-16-52		24c. NAME OF CEMETERY OR CREMATORY Centralia, Illinois (State)	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Galbreath F. H., Centralia, Ill.	
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(Licensed Embalmer's Statement on Reverse Side)

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

FILED MAY 1 - 1952

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 Ben Goffman

Licensed Embalmer No. 4366

P. O. Address New 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.