

FILED FEB 11 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3603**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0957**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp		d. STREET ADDRESS (If rural, give location) 918a LaSalle	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) WILLIAM	b. (Middle) JOHN	c. (Last) PETERS	Jan 26 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 10, 1880		
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months		IF UNDER 6 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer & manufacturer		10b. KIND OF BUSINESS OR INDUSTRY Cigars		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME John W Peters		13b. MOTHER'S MAIDEN NAME Gertrude Jansen		14. NAME OF HUSBAND OR WIFE Rose M Peters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rose M Peters 918a LaSalle	

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) Pulmonary Infarct		PRECEDENT CAUSES Metastatic Carcinoma		2-4 mos	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Metastatic Carcinoma			
		DUE TO (c) Carcinoma of prostate		1 year	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 177X	

22. I hereby certify that I attended the deceased from **Jan 13, 1953**, to **Jan 26, 1953**, that I last saw the deceased alive on **Jan 26, 1953**, and that death occurred at **1:50P** m., from the causes and on the date stated above.

23a. SIGNATURE Frank G. Snydel M.D.		23b. ADDRESS 16 Hampton Village Plaza		23c. DATE SIGNED 1-27-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 29, 53		24c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul	
				24d. LOCATION (City, town, or county) (State) St. Louis Mo	

DATE REC'D BY LOCAL REG. JAN 27 1953		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette Ave	
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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

John B. Hollman

Licensed Embalmer No. 4014

P. O. Address 3125 2nd St

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.