

No. 300
10-48

FILED JAN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44286**

BIRTH NO. **80182-54** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **2888**

1001

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

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give town(ship)) St. Ann | | c. CITY OR TOWN St. Ann 407 / 0 d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. LENGTH OF STAY (in this place) 4 Wks | | STREET ADDRESS (If rural, give location) 3314 St. Joachim Lane | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3314 St. Joachim Lane. | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Deborah b. (Middle) Jane c. (Last) Peters | | 4. DATE OF DEATH (Month) (Day) (Year) Dec. 15 1954 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH Nov 16, 1954 |
| 9. AGE (In years last birthday) 28 | | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during previous year or last year if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | |
| 11a. FATHER'S NAME August Peters | | 11b. MOTHER'S MAIDEN NAME Rosemary Rickert | |
| 11c. NAME OF HUSBAND OR WIFE NONE | | 11d. CITIZEN OF WHAT COUNTRY? U.S.A. | |

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|---|--|--|--|---|--|
| 13a. FATHER'S NAME August Peters | | 13b. MOTHER'S MAIDEN NAME Rosemary Rickert | | 14. NAME OF HUSBAND OR WIFE NONE | |
| 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 August Peters | |
| | | | | ADDRESS 3314 St. Joachim Lane | |

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|---|--|---|--|---|--|
| 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. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration of Mucus | | INTERVAL BETWEEN ONSET AND DEATH Peritonitis 1 hour | |
| ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Upper Respiratory Infection 9 days | | DUE TO (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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|---|--|--|--|---|--|
| 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) 7620 | |
| 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? | |

22. I hereby certify that I attended the deceased from **Nov 16, 1954**, to **Dec 15, 1954**, that I last saw the deceased alive on **Dec 15, 1954**, and that death occurred at **12:34 p.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) J. J. McNamee, M.D. | | 23b. ADDRESS 12300 St. Charles Rd., St. Louis, Mo. | | 23c. DATE SIGNED Dec 15, 1954 | |
| 24a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal | | 24b. DATE Dec 15 1954 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | |
| 24d. LOCATION (City, town, or county) (State) St. Louis Mo. | | 24e. FUNERAL DIRECTOR'S SIGNATURE Heather K. Smith | | 24f. ADDRESS Hollier Mortuary 10123 St. Chas. Rd. | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | |

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.....
Signature of Student Embalmer

Signed *Sheldon Collier*.....

Licensed Embalmer No. *338*

P. O. Address *10123 St. 4*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.