

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6410**  
**1617**  
Registrar's No.

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>Mo.</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4548 Flora Blvd.</b>			STREET ADDRESS (If rural, give location) <b>17 4548 Flora Blvd.</b>					
3. NAME OF DECEASED (Type or Print) <b>VIOLET</b>			a. (First) _____		b. (Middle) <b>M.</b>		c. (Last) <b>PEPPLE</b>	
4. DATE OF DEATH <b>Feb. 18 1955</b>		(Month) _____ (Day) _____ (Year) _____		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Aug. 13, 1902</b>		9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR: Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Mary's Mo. D</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>James Tucker</b>			13b. MOTHER'S MAIDEN NAME <b>Inez Mary Pecaut</b>		14. NAME OF HUSBAND OR WIFE <b>Delbert D. Pepple</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Delbert D. Pepple</b> ADDRESS <b>4548 Flora Blvd.</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma left ovary</b> ANTECEDENT CAUSES <b>None</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
19a. DATE OF OPERATION <b>Sept 1954</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma left ovary</b>				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) _____		21f. HOW DID INJURY OCCUR? <b>175 ft</b>		
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
22. I hereby certify that I attended the deceased from <b>May 19 54</b> , to <b>Feb 18 55</b> that I last saw the deceased alive on <b>Feb 18 1955</b> , and that death occurred at <b>9:05 P</b> m., from the causes and on the date stated above.								
23a. SIGNATURE <b>John S. Matthews M.D.</b> (Degree or title) _____				23b. ADDRESS <b>2207 Watson Rd</b>		23c. DATE SIGNED <b>2-19-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Feb. 22, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
DATE REC'D BY LOCAL REG. <b>FEB 21 1955</b>		REGISTRAR'S SIGNATURE <b>Charles Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway Bl.</b>				

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

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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 *Richard W. Storran*.....

Licensed Embalmer No. *400*.....

P. O. Address.....

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.