

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10869

STATE FILE NUMBER

FILED MAR 18 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

959

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jefferson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN House Springs		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp			Length of stay in 1b		d. STREET ADDRESS Rt. #2		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle H Last Peters				4. DATE OF DEATH Month Jan Day 28 Year 1957					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 1, 1891		9. AGE (In years last birthday) 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY butcher		11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Peters				14. MOTHER'S MAIDEN NAME not known					
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 Address Emma Peters RR #2. House Springs Mo.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT HEMORRAGE								INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____						DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION			COUNTY		STATE
21. I attended the deceased from 1-26-57 to 1-28-57 and last saw ^{him} her alive on 1-28-57 Death occurred at 11:30p m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Henry Stouffer MD				(Degree or title) MD		22b. ADDRESS 815 Oliv St St Louis Mo		22c. DATE SIGNED 1/29/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1/31/1957	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park			23d. LOCATION (City, town, or county) (State) St. Louis Co, Mo.			
24. FUNERAL DIRECTOR J L Ziegenhein & Sons 7027 Gravois					ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 30 '57		26. REGISTRAR'S SIGNATURE Carl Smith MD

(Licensed Embolmer's Statement on Reverse Side)

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.....
Don Berg

Licensed Embalmer No. *486*

P. O. Address *7027*

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.