

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42451
11754

FILED DEC 13 1957

318

1003

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		c. CITY OR TOWN ST LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST JOHNS HOSP.		d. STREET ADDRESS (If outside, give location) 3622 1/2 BAMBERGER	
3. NAME OF DECEASED (Type or print) First LOUIS Middle PETERSON Last		4. DATE OF DEATH Month DEC Day 5 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 6 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NAVAL OFFICER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI
13a. FATHER'S NAME LOUIS PETERSON		13b. MOTHER'S MAIDEN NAME HULDA HAMMERGREN	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WORLD WAR I AND 2		16. SOCIAL SECURITY NO. NONE	17. INFORMANT HELEN BUELLER Address 3622 1/2 BAMBERGER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x			INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs 10 yrs
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 a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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: April 1952 to Dec 5 27 and last saw her alive on Dec 5, 1957 Death occurred at 2:05 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William A. Starnes MD		22b. ADDRESS 4401 Hampton	
22c. DATE SIGNED 12/6/57			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
REMOVAL	DEC 7 1957	MEMORIAL PARK CEM	ST LOUIS COUNTY MO
24. EMBALMER DIRECTOR Thomas Kutis ADDRESS 2906 Gravois		25. DATE RECD. BY LOCAL REG. DEC 7 57	26. REGISTRAR'S SIGNATURE J. Earl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

