

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038099

STATE FILE NUMBER

NOV 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10186

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>4166 Lindell Blvd.</b>	
Length of stay in lb <b>7 1/2 hours</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED <b>William M. Edmund Peters</b> (Type or print)		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>24</b> Year <b>1958</b>	
<b>William Edmund Peters.</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12th, 1901</b>
		9. AGE (In years last birthday) <b>57</b>	9. AGE (In years) IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Private Detective</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Detective</b>	11. BIRTHPLACE (City and state or country) <b>Herithes Pennsylvania</b>
		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Edmund Peters</b>		13b. MOTHER'S MAIDEN NAME <b>Lytell</b>	14. NAME OF HUSBAND OR WIFE <b>Katherine Peters</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>547-15-8251</b>	17. INFORMANT Address <b>Mrs. Edmund Peters 4166 Lindell Blvd.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma due to metastatic carcinoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CARCINOMA OF LEFT LUNG.</b>			<b>6 mos.</b>
DUE TO (c) <b>163x</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 <b>Aug 1st 1958</b> to <b>OCT 24 1958</b> and last saw <sup>him</sup> alive on <b>OCT 23 1958</b> . Death occurred at <b>2:40A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>B. T. M. Fry</b> (Degree or title) <b>MD.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>24 Oct 58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal R.R.</b>	23b. DATE <b>10-27-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Salem Ohio</b>
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>	ADDRESS <b>3840 Lindell Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 24 '58</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith MD</b> <i>mjb.</i>

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.

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 *Wm J. Dallen* .....

Licensed Embalmer No. *4699* .....  
P. O. Address *3840 L... ..*

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.