

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038991

STATE FILE NUMBER

FILED DEC 15 1958 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1322

1. PLACE OF DEATH a. COUNTY Bucha nan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2209 Francis St.		Length of stay in 1b 60 Years	d. STREET (If outside, give location) ADDRESS 2209 Francis St.
3. NAME OF DECEASED (Type or print) First Middle Last Hazel Marie Peters			4. DATE OF DEATH Month Day Year Dec. 9, 1958
5. SEX Female	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. 22, 1898
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and state or country) St. Joseph, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Ira C. Peters		13b. MOTHER'S MAIDEN NAME Sarah E. Metz	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. L. T. Howard 2209 Francis St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO (b) Tareplegia DUE TO (c) Polio Residue (Convulsions)			INTERVAL BETWEEN ONSET AND DEATH Jan 24 hrs 59 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 081X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 081X	
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 12/8/58 to 12/9/58 and last saw her alive on 12/8/58 Death occurred at 3:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Clifton Smith M.D.		22b. ADDRESS 218 No 7th St Joseph	22c. DATE SIGNED 12/10/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, County) (State)
Burial	Dec. 11, 1958	Memorial Park	St. Joseph, Mo.
24. FUNERAL DIRECTOR Eark A. Clark 120 Illinois Ave.		25. DATE RECD. BY LOCAL REG. Dec. 11, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

All diseases in Part I must be causally related.

Br. Clifton Smith

MEDICAL CERTIFICATION

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 *Paul F. Clark*

Licensed Embalmer No. *5024*

P. O. Address *St. Joseph, Mo.*

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.