

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047330

STATE FILE NUMBER

11971

318

1003

FILED FEB 26 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>1</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u> ²¹⁴⁹ / ₀ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
5. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>15 LUTHERAN Hosp.</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>14 5070 - OLEATHA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM W. PETERS</u>			4. DATE OF DEATH Month Day Year <u>DEC. 11 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20 1896</u>
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>KENTUCKY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>WILLIAM PETERS</u>	
13b. MOTHER'S MAIDEN NAME <u>FRANCES WRIGHT</u>		14. NAME OF HUSBAND OR WIFE <u>LOLA PETERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WAR I</u>		16. SOCIAL SECURITY NO. <u>490-01-7096</u>	
17. INFORMANT <u>LOLA PETERS</u>		Address a <u>5070 - OLEATHA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage causing hemiplegia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>331X</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1/18-17/11</u>
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 Death occurred at <u>11/18</u> to <u>12/11</u> and last saw her alive on <u>12-11-1958</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ralph Berg</u>		22b. ADDRESS <u>3203 S. Grand</u>	
22c. DATE SIGNED <u>12/12/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>DEC. 12 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>MEMPHIS TENNESSEE</u>	
24. FUNERAL DIRECTOR <u>Thomas Kuttis 2906 Lewis</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 12 '58</u>	
26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

FEB 26 1956

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 *James C. Hill*

Licensed Embalmer No. *4347*
P. O. Address *2906 Grand*

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.