

Health, Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003816  
STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 169

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirkwood 46830</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>337 W. Argonne Dr.</b>		Length of stay in 1b <b>51 years</b>	d. STREET ADDRESS (If outside, give location) <b>337 W. Argonne Dr.</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ARTHUR</b> Last <b>PETERS</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>15,</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1864</b>	9. AGE (In years at birth) <b>94</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical Engineer</b>	11. BIRTHPLACE (City and state or country) <b>Birkenhead, England 4</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Frederick Peters</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Evans</b>	14. NAME OF HUSBAND OR WIFE <b>Gertrude Peters</b>
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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>None</b>	17. INFORMANT <b>Alice Bolay, 337 W. Argonne Dr., Kirkwood, Mo.</b>	Address
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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>Infirmity of Age</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b> <b>10 yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Myocardial degeneration</b>	
	DUE TO (c) <b>Arterio-Sclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Gradual Exhaustion - 4221</b>		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.) <b>—</b>
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20c. TIME OF INJURY Hour <b>—</b> Month, Day, Year <b>—</b> a.m. <b>—</b> p.m. <b>—</b>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. CITY, TOWN, OR LOCATION <b>—</b>	COUNTY <b>—</b>	STATE <b>—</b>
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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.) <b>—</b>	20f. CITY, TOWN, OR LOCATION <b>—</b>	COUNTY <b>—</b>	STATE <b>—</b>
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21. I attended the deceased from **6 yrs -** to **—** and last saw him alive on **Jan 3 - 1959 -**  
Death occurred at **Home** **12:50 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Alice Bolay</b>	(Dee or title)	22b. ADDRESS <b>Kirkwood, Mo.</b>	22c. DATE SIGNED <b>1/16/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/16/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kirkwood, Mo.</b>	(State)
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24. FUNERAL DIRECTOR <b>Louis H. Bopp</b>	Address <b>Kirkwood</b>	25. DATE RECD. BY LOCAL REG. <b>1-18-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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(Witnessed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

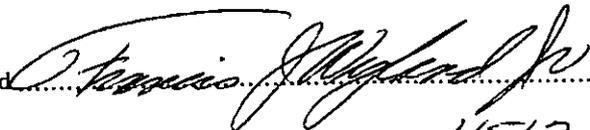
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

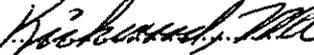
STATEMENT BY LICENSED EMBALMER

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  \_\_\_\_\_

Licensed Embalmer No. 4572

P. O. Address 

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.