

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027063

FILED VS JUL 24 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 6502**

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 98 yrs	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Booth Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3811 Kosciusko Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MINNA Middle K. Last PETERS			4. DATE OF DEATH Month July Day 8 Year 1959		
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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 3/5/1861	9. AGE (last birthday) 98	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Henry Wm. Peters	13b. MOTHER'S MAIDEN NAME Wilhelmina Landwehr	14. NAME OF HUSBAND OR WIFE none
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Miss Dorothy Peters, 3519 Lawn Avenue 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) Paralysis of neck		INTERVAL BETWEEN ONSET AND DEATH 6/25/59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Encephalomalacia of Brain due to arteriosclerosis	6/25/09
	DUE TO (c) Arteriosclerosis General	more than 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from **June 17 1959** to **July 8, 1959** and last saw her ^{her} _{him} alive on **July 7, 1959**
Death occurred at **2:30 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Leroy E. Ellison MD (Degree or title)	22b. ADDRESS 3610 So Broadway St, Louis, Mo	22c. DATE SIGNED July 8, 1959 (Date)
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE July 10, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
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24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 10 59	26. REGISTRAR'S SIGNATURE Carl Smith M.D.
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M. J. B.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. LeRoy E. Ellison,
3610 So. Broadway
1 - 4 PM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *David L. [Signature]*

Licensed Embalmer No. 452

P. O. Address *Albany*

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.