

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961

-61-000021  
STATE FILE NUMBER

WRITE THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 1

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4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

TYPEWRITER RIBBON

ITEM NO. SHOULD READ

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Adair</b>  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Sullivan</b> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kirksville</b>   |  | Length of stay in 1b<br><b>5 days</b>   | c. CITY OR TOWN <b>Osgood</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Grim-Smith Hospital</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>RFD</b>  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Moses Eldorado Peters</b>   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>January 1 1961</b>  |  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 2, 1875</b>   | 9. AGE (last birthday)<br><b>85</b>  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>2</b> Hours <b></b> Min. <b></b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>farming</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Sullivan Co., Mo.</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>  |
| 13a. FATHER'S NAME<br><b>Silas Peters</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Katherine Weston</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Elizabeth K. Peters</b>                                    |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  | 17. INFORMANT Address<br><b>Zona Boehner-Humphrys, Mo.</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>   |  |   |  |  | <b>Immediate</b>  |
| DUE TO (b) <b>Multiple thrombi (leg, brain)</b>  |  |   |  |  | <b>3 weeks</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)<br><b>leg. Recent stroke left. Gangrenous left leg</b>   |  |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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.) |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |  | 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   |
| 21. I attended the deceased from <b>12-28-60</b> to <b>1-1-61</b> and last saw <sup>her</sup> him alive on <b>1-1-61</b><br>Death occurred at <b>11:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>[Signature]</b>   |  |   | 22b. ADDRESS<br><b>Kirksville, Mo.</b>   |  | 22c. DATE SIGNED<br><b>1/3/61</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 23b. DATE<br><b>1/4/1961</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Camp Ground Cemetery</b>  |  | 23d. LOCATION (City, town, or county)<br><b>Sullivan Co., Mo.</b>   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>E. K. Payne, Galt, Mo.</b>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>Jan. 3, 1961</b>  |  | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |

J. J. W. M. P., M.D.

**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 R. Jackson

Licensed Embalmer No. 3954

P. O. Address Kerrville *TX*

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.