

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

VS JAN 16 1961
AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **190** **61-008519**

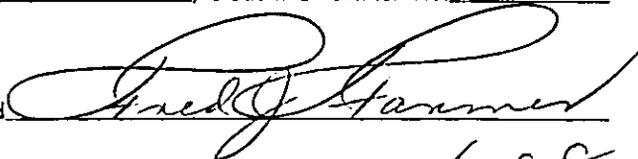
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b		c. CITY OR TOWN Jennings		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2437 Hord		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALICE Middle I. Last PEEK				4. DATE OF DEATH Month January Day 6, Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1890	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months 5 Days 4	IF UNDER 24 HR Hours 3 Min. hrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) Vernon, Texas		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Charles Anderson Mason			13b. MOTHER'S MAIDEN NAME Laura Kirkpatrick		14. NAME OF HUSBAND OR WIFE Robert R. Peek		
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 Elizabeth Kessler, 2437 Hord			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cerebral Anoxia						3 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Hypostatic Pneumonia						6 days	
DUE TO (c) Chronic Hypertensive Heart Failure						unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive Cardiovascular-renal Disease					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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 442 x			
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	
21. I attended the deceased from 1 Dec 60 to January 6, 1961 and last saw him her live on January 6, 1961				Death occurred at 5:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leonard J. Kopp			22b. ADDRESS M.D. 6917 W. Florissant		22c. DATE SIGNED 1/6/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 9, 1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd.			25. DATE RECD. BY LOCAL REG. JAN 7 1961		26. REGISTRAR'S SIGNATURE Leon Smith, 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  _____

Licensed Embalmer No. 4788

P. O. Address St. Louis, 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.