

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032784

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8133 STATE FILE NUMBER

FILED AUG 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3525 Arsenal St.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First DR. TERRELL Middle C. Last PETER			4. DATE OF DEATH Month Aug. Day 20 Year 1962			5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2-23-1893		9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor-Self Employed						10b. KIND OF BUSINESS OR INDUSTRY Metropolis, Ill.						11. BIRTHPLACE (City and state or country) U.S.A.						12. CITIZEN OF WHAT COUNTRY					
13a. FATHER'S NAME George W. Peter						13b. MOTHER'S MAIDEN NAME Anna Obermark						14. NAME OF HUSBAND OR WIFE Erma C. Peter											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I						16. SOCIAL SECURITY NO.						17. INFORMANT Address Erma C. Peter 3525 Arsenal St.											
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct (after colostomy) intestinal obstruction DOE TO (b) Carcinoma of sigmoid 153.3 DOE TO (c) Arteriosclerotic heart - disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart - disease PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown												INTERVAL BETWEEN ONSET AND DEATH 6 hours 4 days 2 weeks month											
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.)																			
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 1957 to 8-20/62 and last saw him alive on 8-20-62 Death occurred at 12:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE (Degree or title) Maximilian Weilmann, M.D.						22b. ADDRESS 3530 ARSENAL, St. Louis						22c. DATE SIGNED 8-21-62											
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug. 22, 1962		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery				23d. LOCATION (City, town, or county) St. Louis Co. Mo.				(State)											
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.						25. DATE RECD. BY LOCAL REG. AUG 21 1962						26. REGISTRAR'S SIGNATURE Loan Smith, M.D.											

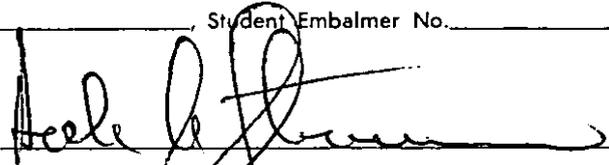
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STATEMENT BY LICENSED EMBALMER

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. 4533

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.