LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 33333

or

Village ..... Primary Registration District No. 1003 Registered No. 9710

or

City St Louis Mo (NO. City Hospital St. 6 Ward)

8404

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Peter Peterson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Nov (Month) 15 (Day), 1862 (Year)

7 AGE: 55 yrs. 10 mos. 28 ds.

If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Lab.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): Sweden

PARENTS

10 NAME OF FATHER: Peter Olsen

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Sweden

12 MAIDEN NAME OF MOTHER: Bertha Olsen Nee

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Sweden

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto R Fritsch

(Address) City Hospital

15 Filed OCT 17 1918, 191 Mark C Starkloff Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 13 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 9, 1918, to Oct 13, 1918, that I last saw him alive on Oct 13, 1918, and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Influenza

10

11A

10 7A (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) Emil C Heim M. D.

Oct 14, 1918 (Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. 4 ds. In the State 30 yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence: Erie House

19 PLACE OF BURIAL OR REMOVAL: St Mathews

DATE OF BURIAL: Oct 17, 1918

20 UNDERTAKER: E. L. Schnur

ADDRESS: 2652 Chouteau

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX .....

4 COLOR OR RACE .....

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) .....

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) .....

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) .....

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 ..... 191 .....

Filed ..... 191 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... (Day) ..... 191 ..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 191 ..... to ..... 191 ..... that I last saw h ..... alive on ..... 191 ..... and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 191 ..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL ..... 191 .....

20 UNDERTAKER ..... ADDRESS .....