

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

Do not use this space.

17189

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City Hospital)

File No.
Registered No. 6050
St. Ward

2. FULL NAME Arroy Peterson

(a) Residence. No. 111 Clark St., 25 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

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

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 5 - 1860

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

67

25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

day

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Sweden

10. NAME OF FATHER

Nelson Peterson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Sweden

12. MAIDEN NAME OF MOTHER

Sophia Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Sweden

14.

INFORMANT

(Address)

Arroy Peterson
City Hospital

15.

FILED 30 1927

Mar. C. Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR)

May 30 1927

17.

HEREBY CERTIFY, That I attended deceased from April 22, 1927, to May 30, 1927, that I last saw him alive on May 30, 1927, and that death occurred on the date stated above, at 9:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. myocarditis
hypertrophied prostate
93C
137

CONTRIBUTORY (SECONDARY)

9013

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) S. Hays, M. D.
(Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Washington U. 6/7 27

20. UNDERTAKER

ADDRESS

W. Richter 3500 Rutgers

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.

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