

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

Do not use this space.

*Handwritten:*  
1797

FEB 21 1928

1. PLACE OF DEATH

County *Macon*  
Township *Chariton*  
City *Wm C Teter* (No. ....) St. .... Ward .....

Registration District No. *529*  
Primary Registration District No. *5705*

File No. ....  
Registered No. ....  
Ward .....

2. FULL NAME

(a) Residence. No. .... St. .... Ward .....

(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX  4. COLOR OR RACE  5. SINGLE, MARRIED, WIDOWED OR DIVORCED  (write the word)

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

*Mrs Ella Teter*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 15, 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

*61 2 15*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Farmer.*

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

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*Macon Co Mo*

10. NAME OF FATHER

*Jacob C Teter.*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

*Macon Co, Mo*

12. MAIDEN NAME OF MOTHER

*Eliza Stone*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

*Macon Co.*

14.

INFORMANT *Family* (Address)

15.

FILED  REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 30 1928*

17. I HEREBY CERTIFY That I attended deceased *on Jan 30* 19*28*, to *Jan 30* 19*28*, that I last saw him alive on *Jan 30* 19*28*, and that death occurred, on the date stated above, at *9 P.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Myocarditis*

*120 90 P*  
*570 Arthritis* (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: .....

9 DID AN OPERATION PRECEDE DEATH: .. DATE OF ..

WAS THERE AN AUTOPSY? ..

WHAT TEST CONFIRMED DIAGNOSIS

*Clinical*  
*J. R. Hunt*, M. D.  
*1/31*, 19*28* (Address)

\*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

*Mt. Salem Cem.*

*2-1 1928*

20. UNDERTAKER

ADDRESS

*Albert Skinner*

*Macon Mo*

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**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**1. PLACE OF DEATH.**

County Macon  
Township Chariton  
City Wrens

Registration District No. 529  
Primary Registration District No. 5705

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Wm. C. Peters

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 15-1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

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

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_  
12. MAIDEN NAME OF MOTHER \_\_\_\_\_  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Ella Peter  
(Address) R.D. Jacksonville Mo

15. FILED 1-10-1928 J. L. Trippeev  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30 1928

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_  
WAS THERE AN AUTOPSY: \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) \_\_\_\_\_, M. D.  
, 19\_\_\_\_ (Address)

\*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 \_\_\_\_\_  
19

20. UNDERTAKER Albert Skinner  
ADDRESS macon mo

SUPPLEMENTARY

S-1797