

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

Do not use this space.

3449

1. PLACE OF DEATH
 County Stoddard Registration District No. 838
 Township Liberty Primary Registration District No. 6098R
 City (No. _____) St. _____ Ward _____

2. FULL NAME George Abraham Peachenor
 (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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. _____

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 Julia Peachenor

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch - 27 - 1863

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>68</u>	<u>9</u>	<u>5</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) none
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ridgway Ill. 2

10. NAME OF FATHER ? - Peachenor

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

12. MAIDEN NAME OF MOTHER ? - Smith

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

14. INFORMANT W. C. Peachenor
 (Address) Dexter Route 1

15. FILED 1-2-1932 F. LaRue
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan - 2 - 1932

17. I HEREBY CERTIFY, That I attended deceased from _____
1 - 1 - 1924 to July - 15 - 1930
 that I last saw him alive on July 15 - 1930, and that death occurred, on the date stated above, at _____ 2 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy - Rt. sided paralysis.
(This illness was insiduous and had been for 2 years. No physician present at death) (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Cardio-vascular renal disease. (duration) 8 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH. NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Histology
 (Signed) Frank LaRue, M. D.
 , 19 _____ (Address) Dexter Mo.

*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 Taylor Cemetery DATE OF BURIAL 1-3-1932

20. UNDERTAKER CO Briggs & Co. ADDRESS Dexter 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.

