

JAN 19 1938

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

Do not use this space.

45818

97

1. PLACE OF DEATH
 54 County Lexington Registration District No. 461
 Township Lafayette Primary Registration District No. 3096
 City Lafayette (No. 1) (St. Mo. Ward 1)

2. FULL NAME Amelia May Peek

(a) Residence, No. 1 St. 1 Ward. 1
 (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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 18, 1937 1937

22. I HEREBY CERTIFY, That I attended deceased from 12-17, 1937, to 12-18, 1937

I last saw her alive on 12-18, 1937. Death is said to have occurred on the date stated above, at 12:15 p. m.

The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 23, 1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.

26

Lobular Pneumonia

Date of onset

Other contributory causes of importance

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. -----

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. -----

10. Date deceased last worked at this occupation (month and year) -----

11. Total time (years) spent in this occupation -----

12. BIRTHPLACE (CITY OR TOWN) Lexington (STATE OR COUNTRY) Mo.

13. NAME Earl Peek

14. BIRTHPLACE (CITY OR TOWN) Lexington (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Charlott Owens

16. BIRTHPLACE (CITY OR TOWN) Barton, Co. Mo. (STATE OR COUNTRY)

17. INFORMANT Earl Peek (ADDRESS) Lexington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lexington, Mo. DATE Dec. 19, 1937

19. UNDERTAKER Winkler (ADDRESS) Lexington, Mo.

20. FILED Dec 19, 1937 F. B. Bales Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. J. Gilman, M.D. _____

(Address) Lexington, Mo.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

107a

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

45-818
Do not use this space.

1. PLACE OF DEATH
 (a) County Lafayette Registration District No. 461
 (b) Township Leighton Primary Registration District No. 3625-
 (c) City _____ (d) Street No. _____ Registered No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Amelia May Peck
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 26
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED 3/18/38 19 W. H. Gilbert Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 18 1937
 22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Lobular Pneumonia Date of onset _____
 Other contributory causes of importance:
No Complication
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) H. H. Gilbert M.D.O.
 (Address) Leighton Mo

SUPPLEMENTARY

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

