

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

25739
Do not use this space.

REC'D AUG 25

1. PLACE OF DEATH
 (a) County Laclede Registration District No. 448
 (b) Township Union Primary Registration District No. 5-608 Registered No. 9
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Phillip M. Peters Bl.?
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 3 1

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

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) Laclede Co. Mo.

FATHER 13. NAME Jonathan Peters
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Sarah Rader
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT Mrs Dellia Peters
 (ADDRESS) Conway Mo Ark

18. BURIAL, CREMATION, OR REMOVAL PLACE Morgan DATE 7/12/38

19. FUNERAL DIRECTOR W.E. Halman
 (ADDRESS) Lebanon Mo

20. FILED 8-4 1938 ARA, MONTGOMERY
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/9 1938

22. I HEREBY CERTIFY That I attended deceased from May 11, 1938, to July 9, 1938
 I last saw him alive on July 19, 1938. Death is said to have occurred on the date stated above, at 9:30 am.
 The principal cause of death and related causes of importance were as follows:

Cancer of Prostate Gland and bladder Date of onset 1937

Other contributory causes of importance:
Cystic Renal fistula May 1938
Peritonitis July 7/1938
 Name of operation Drainage of Bladder Date of 5/15/38
 What test confirmed diagnosis? Culture Was there an autopsy? no.

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? no.
 If so, specify _____
 (Signed) Dr. Taylor _____ M. D.
 (Address) Phillipsburg, 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.

STATEMENT BY LICENSED EMBALMER

W. E. Holman

Licensed Embalmer No. *3061*

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

Myself

L. E.

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed

W. E. Holman

Licensed Embalmer No. *3061*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
EMBALMERS
REGISTRATION AND EXAMINATION
SECTION

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25-739

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 448
(b) Township Union Primary Registration District No. 36.08 Registered No. 9
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Philip M. Peters

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(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.
57 3 1

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. MAFDEN 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, 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/9 1938

22. I HEREBY CERTIFY, That I attended deceased from 19... 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:

Cancer of prostate gland and bladder Date of case

Other contributory causes of importance: 510

Name of operation Date of

What was 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) E. Saylor, M. D.

(Address) Phillipsburg, 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.

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

SUPPLEMENTARY

