

Registration District No.

1008

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town ST. LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: (In hospital or institution) _____ (Specify whether _____)
 In this community _____
 years, months or days)

8. (a) PRINT FULL NAME JACOB R. PECK 200

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CELESTIA PECK 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased APRIL 4 1867
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>4</u>	<u>10</u>	____ hr. ____ min.

9. Birthplace ILLINOIS
(City, town, or county) (State or foreign country)10. Usual occupation BARBER

11. Industry or business _____

12. Name PERRY PECK18. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)14. Maiden name EMMA UNK15. Birthplace OHIO
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Celestia Peck(b) Address 3704 Laclède av17. (a) BURIAL (b) Date thereof AUG 16 - 39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation ST. MATTHEWS18. (a) Signature of funeral director E. J. Schmur(b) Address 3125 Lafayette av19. (a) AUG 16 1939 (b) _____
(Date received local registrar) (Registrar's initials)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
 (c) City or town ST. LOUIS [18]
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3704 LACLÈDE AV.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14
 year 1939 hour 6 minute 35 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage (apoplexy)ArteriosclerosisDue to found

Due to _____

Other conditions 82 W
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? H

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature Joseph M. DunbarAddress Deputy Coroner Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Jos B Vollmer*

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette*

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.)

If this body is not embalmed, above space should be left blank.