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.

61

REC'D SEP 15 1939

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

29645
Do not use this space.

1. PLACE OF DEATH
(a) County Macon 1 Registration District No. 529
(b) Township Monroe Primary Registration District No. 5706 Registered No.
(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 360 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
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~~ Margaret Ann Peter
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 6" 1858
7. AGE YEARS 81 MONTHS 5 DAYS 14 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
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) Macon Co. Mo.

FATHER
13. NAME Manasa Peter
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

MOTHER
15. MAIDEN NAME Sallie Leathers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

17. INFORMANT Mrs Henry Leidorff
(ADDRESS) Callao, Mo. R.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Hebron Cem. DATE July 21" 1939

19. FUNERAL DIRECTOR (NAME) Stephens & Goodding
(ADDRESS) Macon, Mo. 472

20. FILED Aug 21, 1939 Mrs R. W. Dowell
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20" 1939

22. I HEREBY CERTIFY, That I attended deceased from april, 1937, to July 19, 1939
I last saw him alive on July 19, 1939. Death is said to have occurred on the date stated above, at 5-00 a.m.
The principal cause of death and related causes of importance were as follows:

The Chronic ~~Pericarditis~~ Pericarditis

Date of onset

Other contributory causes of importance: 116

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) F. L. Trippeer, M. D.
(Address) College mound Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-39-1570
Date Filed SEP 8 1939

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, Geo Stephens, or by

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

Signed Geo. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, Mo

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

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