

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: 4021 Glasgow
(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 Louis F. Peiker

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Peiker 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 11 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72-10 20 _____ hr. _____ min.

9. Birthplace Pittsburg Pa.
(City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business Butcher

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant Walter Peiker
(b) Address 408 8611 Park Lane

17. (a) Burial (b) Date thereof Mar 4, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director John A. Genteman
(b) Address 5077 Durant Ave.

19. (a) MAR 4 1940 (b) _____
(Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town City of St. Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 4021 Glasgow
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1 1940
year 1940 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from May 15, 1939 to March 1, 1940
that I last saw him alive on March 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 5-15-39

Due to Arteriosclerosis 5-15-39

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W. Emmett Jones (M. D. or other) M.D.
Address 380 S. N. Standard Date signed 3-2-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Guy W. Wilkinso

Licensed Embalmer No. 3575

P. O. Address _____

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.