

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

11028

Do not use this space.

1. PLACE OF DEATH <sup>2</sup>  
 (a) County Green Registration District No. 290  
 (b) Township Robinson Primary Registration District No. 1111 Registered No. \_\_\_\_\_  
 or \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. Brighton, Missouri 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 HOWARD J. NERS PECK  
 (a) Residence, No. Brighton, Missouri  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 4 - 1899

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
<u>40</u>	<u>11</u>	<u>6</u>	<u>6</u>	

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

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) Missouri 0

FATHER

13. NAME Robert R. Peck 0

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 0

MOTHER

15. MAIDEN NAME Lillie McDaniel

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Rubey Peck Brighton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE West, Friday DATE 3-12 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hutchinson & Co.

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 4 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 10 - 1940 to Apr 4 1940  
 I last saw h. or alive on 3/5 1940 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:  
Carcinoma of the  
40  
 Date of onset Apr 1939

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? X-Ray 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? \_\_\_\_\_  
 If so, specify Chronic Fatigue \_\_\_\_\_ M. D.  
 (Signed) \_\_\_\_\_  
 (Address) Quincy, Mo.

Local Registrar

(Licensed Embalmer's Statement on Reverse Side)

Exact statement of OCCUPATION is very important. Cause of DEATH in plain terms, so that it may be properly classified. An accurate statement of information should be carefully checked.

39

RECEIVED

District Health Officer No. 7,

District File Number *H-40-561*

**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 *A. B. Hutchison*

Licensed Embalmer No. *1331*

P. O. Address *Bolivar*

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

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

*X*

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11028

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 324

Primary Registration District No. 3449

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Green  
(b) City or town Robinson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME Thers Peck

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 40 Months 11 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) April 6-40 (b) Mrs. Guy Freeman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month apr day 4  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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) Means of injury \_\_\_\_\_

23. Signature C. H. Meitch (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

1940  
5-11028