

No. 2  
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5-17-39  
PI X21492

RECEIVED FEB 18 1941

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 30

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

1. PLACE OF DEATH:  
(a) County Vernon  
(b) City or town Rural (Washington, Mo.)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hosp. #3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 mos 2 days  
(Specify whether  
In this community same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County None 108  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1572<sup>a</sup> S Vandeventer  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Foances Petera  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. 2-2-2

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 28<sup>th</sup>  
year 1941 hour 1:45 minute 0 M.

4. Sex M  
5. Color or race W  
6. (a) Single, widowed, married, divorced Div  
(b) Name of husband or wife Matthew Petera  
(c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from 1-28-41, 19\_\_\_\_, to 1-28, 1941  
that I last saw her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

7. Birth date of deceased: Dec 19 87  
(Month) (Day) (Year)

Immediate cause of death Lobar Pneumonia (R lobe)  
Duration 6 days

8. AGE: Years 53 Months 1 Days 9  
If less than one day hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Stenographer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Matthew Petera  
13. Birthplace Bohemia  
(City, town, or county) (State or foreign country)  
14. Maiden name Foances Hogan  
15. Birthplace Bohemia  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Keep Records  
(b) Address Nevada mo

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Jan 30 '41  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) Place: burial or cremation Hospital Cemetery

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
795  
(Specify type of place) (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Ray Funeral Serv

123. Signature Dr. Hopkins (M. D. or other) \_\_\_\_\_

(b) Address Nevada mo  
19. (a) 1-28-41 (b) Allen & Hayes  
(Date received local registrar) (Registrar's signature)

#Address Nevada mo Date signed 1/28/41

RECEIVED

District Health Officer No. 7,

District File Number 2-41-231

Date Filed 2-5-41

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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 Allen O. Hays

Licensed Embalmer No. 1968

P. O. Address Neveda, Mo

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.