

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Upshaw

State File No. 28306

FILED SEP 13 1941
318

Registration District No. _____

Primary Registration District No. 2001

Registrar's No. 653

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community 15 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 039
(c) City or town Springfield
(If outside city or town limits, write "RURAL") 16
(d) Street No. 520 Normal
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12
year 1941 hour 10 minute p M.

21. I hereby certify that I attended the deceased from
8-8-41, 19 to 8-12-41, 19
that I last saw him alive on 8-12-41
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis
Due to _____
Due to _____

Other conditions Hemorrhagic ulcers of Colon with
(Include pregnancy within 3 months of death)
bleeding

Major findings:
Of operations none
Of autopsy note done

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 Paul O. Upshaw, (M. D. or other)
Address Springfield, Missouri Date signed 8-15-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Preston A. Peer

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

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

6. (b) Name of husband or wife Grace M. Peer 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Feb 24 1876
(Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Merchant

11. Industry or business Retail Hardware

12. Name James K. Peer

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

14. Maiden name Sarah Caruc

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

16. (a) Informant Horace Peer

(b) Address Springfield Mo

17. (a) Burial (b) Date thereof Aug 14/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Herman Bohmeyer

(b) Address Springfield Mo
19. (a) 8-14-41 (b) W. E. Haudley
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

984

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

9
2
6

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

Signed *L. Paulini Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield Ma*

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, fact should be so stated above.