

FILED JUN 8 1943

Registration District No. 198

Primary Registration District No. 5719

Registrar's No. 27

1. PLACE OF DEATH: *Macon*
(a) County *Macon*
(b) City or town *Bevier Rural*
(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 *-*
of *-* years, months or days)

3. (a) PRINT FULL NAME *Charles peschell*
3. (b) If veteran, name war *-* 3. (c) Social Security No. *-*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, widowed, married, divorced *Married*
6. (b) Name of husband or wife *Hannie Peschell* 6. (c) Age of husband or wife if alive *6.6* years
7. Birth date of deceased *4-18-1956*
(Month) (Day) (Year)

8. AGE: Years *87* Months *1* Days *4* If less than one day *hr. min.*

9. Birthplace *Germany 4*
(City, town, or county) (State or foreign country)

10. Usual occupation *Coal Miner*

11. Industry or business

MOTHER FATHER { 12. Name *Carl M. Peschell*
13. Birthplace *Germany 4*
(City, town, or county) (State or foreign country)
14. Maiden name *Henrietta Worth*
15. Birthplace *Germany 4*
(City, town, or county) (State or foreign country)

16. (a) Informant *Hannie Peschell*

(b) Address *Bevier Mo*

17. (a) *Rural* (b) Date thereof *5-21-43*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *La Graceland*

18. (a) Signature of funeral director *Dr. Edward*

(b) Address *Bevier Mo*

19. (a) *5-27-43* (b) *Winnie J. Rowland*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: *61*
(a) State *Mo* (b) County *Mo*
(c) City or town *0*
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) *0*
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *5* day *22*
year *1943* hour *10* minute *15 P.M.*

21. I hereby certify that I attended the deceased from *May 21* 19*43* to *May 22* 19*43*
that I last saw him alive on *May 22* 19*43*
and that death occurred on the date and hour stated above.

Immediate cause of death *Epilepsy* *2 days*
Due to *Arteriosclerosis* *50 years*

Other conditions *Nephritis (Chronic)*
(Include pregnancy within 3 months of death)

Major findings: *131 P*
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) (e) Means of injury *2*
23. Signature *Dr. E. L. Woodhead*
Address *Bevier Mo* Date signed *5/27/43*

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

7-59
X29484

JUN 9 1943

RECEIVED

District Health Officer No. 10

District File Number 6-43-979

Date Filed JUN 7 1943

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

J. S. Edwards

Licensed Embalmer No.

1961

P. O. Address

Bowie, Md.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 198

Primary Registration District No. 5719

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural
(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Peschell

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 4 18 1874
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-27-43 (b) Winnise J. Rowland
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
(c) City or town Bevier Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 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 _____

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 _____

Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-18341