

FILED APR 13 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 3120

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
16 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Rudolph Peters

3. (b) If veteran, name war No  
3. (c) Social Security No. 497-16-1904

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

6. (b) Name of husband or wife Charnotta Peters  
6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased January 15th., 1867  
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 17  
If less than one day 9 hr. 25 min.

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

10. Usual occupation Mgr. & Buyer Eagle Boat Store

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

12. Name Rudolph Peters  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Hagedorn  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Griffin  
(b) Address 6925 Berthold Ave.

17. (a) Burial (b) Date thereof Apr. 5 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Walter Boukoy  
(b) Address 6536 Clayton Rd.

19. (a) APR 3 1944 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6925 Berthold Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 2  
year 1944 hour 9 minute 25 AM

21. I hereby certify that I attended the deceased from 3/28-1944 to 4-2-44 19\_\_\_\_  
that I last saw him alive on 4-2-44 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cordias  
because of husband

Due to Myocardial infarction  
Due to Myocardial infarction

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)  
(e) Means of injury \_\_\_\_\_

23. Signature Dr. Celedonio (M. D. or other) \_\_\_\_\_  
Address 4932 Maryland Date signed 4/4

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

MOTHER FATHER

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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.....

*J. W. Wilkin*

Licensed Embalmer No..... *3578*

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, fact should be so stated above.