

FILED JAN 9 1945

Registration District No. **241**

Primary Registration District No. **6154**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Stoddard**
 (b) City or town **Essex, Mo. Richland**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Surp**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lau Emma Peters**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Myron Peters** 6. (c) Age of husband or wife if alive **44** years
 7. Birth date of deceased **March 29 1904**
 (Month) (Day) (Year)

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

9. Birthplace **Green Co. Ark**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife farm**

11. Industry or business **Farming**

12. Name **Levi Sanders**

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

14. Maiden name **Lizzie Mumball**

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

16. (a) Informant **Myron Peters**

(b) Address **Essex Mo 1**

17. (a) **Burial** (b) Date thereof **Dec 13-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Taylor Cemetery**

18. (a) Signature of funeral director **Walter H. ...**

(b) Address **Essex Mo**

19. (a) **Dec 16 1944** **Nora Irons**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Stoddard**
 (c) City or town **Essex Mo R1**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **10**
 year **1944** hour **3** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **Dec 10** 19**44** to **Dec 10** 19**44**
 that I last saw h. **alive** on **Dec 10** 19**44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Post Partum Hemorrhage**

Due to _____
 Due to _____

Other conditions **Uterine Prolaps**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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)
 (a) Means of injury _____

23. Signature **S. J. ...** (M. D. or other)
 Address **Essex Mo** Date signed **12/15/44**

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

0300C

RECEIVED

District Health Office No. 2

District File Number 145-48

Date Filed 1-5-45

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 *Pyman Steele*
Licensed Embalmer No. *2476*
P. O. Address *Nexter 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, fact should be so stated above.