

6671

FILED JAN 25 1945

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **384**

1. PLACE OF DEATH:
 (a) County St. Louis, Mo.
 (b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 6492 Dale Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Michael J. Peckron
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 498-03-9949
 4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Rose 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Nov. 17 1887
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 12th
 year 1945 hour 4:00 minute A. M.
 21. I hereby certify that I attended the deceased from 1/9/45
 _____, 19____, to 1/9/45 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years 57 Months 1 Days 26
 If less than one day _____ hr. _____ min.

Immediate cause of death Arterio-sclerotic Heart disease
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation Brewery, Anheuser Busch Yeast

11. Industry or business _____
 12. Name John Peckron
 13. Birthplace Michigan
(City, town, or county) (State or foreign country)
 14. Maiden name UNKNOWN
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

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 _____

16. (a) Informant Rose Peckron
 (b) Address 6492 Dale Ave.
 17. (a) Burial (b) Date thereof Jan. 15, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Matthew's Cemetery

23. Where did injury occur? _____ (City or town) (County) (State)
 (a) 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 J. F. Bredeck (M. D. or other) _____
 Address 1515 Lafayette Date signed 1/12/45

18. (a) Signature of funeral director Wacker Aldridge
 (b) Address 3634 Gravois Ave.
 19. (a) JAN 15 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

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

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..... *Frank J. Ireland*
Licensed Embalmer No. *2645*
P. O. Address *St Louis*

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.