

FILED FEB 7 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

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:
4871 San Francisco ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(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. 4871 San Francisco ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Peterson
(b) If veteran, name war no
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 29
year 1945 hour 5 minute 45 a.m.

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced, married
(b) Name of husband or wife Bess Peterson
(c) Age of husband or wife if alive 59 years
7. Birth date of deceased October 18 1877
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 15th 1944 to Jan 28th 1945
that I last saw him alive on Jan 28th 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>3</u>	<u>11</u>	hr. _____ min. _____

Immediate cause of death Pneumonia (lobar)
Duration 3 Day

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

Due to Quick Deceases

10. Usual occupation Office manager

Due to Paralysis agitans (Parkinson)

11. Industry or business retired

Other conditions (Include pregnancy within 3 months of death) _____

12. Name John C. Peterson

Major findings: Of operations 108

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

Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

14. Maiden name Elizabeth Otto

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

16. (a) Informant Mrs. Bess Peterson

(b) Address 4871 San Francisco ave

17. (a) Burial (b) Date thereof Feb. 1- 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director A. Row L. U. Co

(b) Address 2707 No. Grand Blv'd

19. (a) JAN 30 1945 (b) J. F. Bruce
(Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Dr. Marie T. ... (M. D. or other) _____
Address 11th Security Bldg Date signed 1/29/45

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..... *V. E. Morris*

Licensed Embalmer No..... *3360*

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.