

**FILED FEB 20 1946**  
Registration District No. **20 &**

Primary Registration District No. **5762**

Registrar's No. **60**

1. PLACE OF DEATH:

(a) County **Marion**  
(b) City or town **Durham Twp Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Round Grove (Twp)**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community **Life**  
years, months or days

3. (a) PRINT FULL NAME

**John Peak**  
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 **Widowed**  
6. (b) Name of husband or wife **John Peak** 6. (c) Age of husband or wife if alive **Deceased** years  
7. Birth date of deceased **April 20 1865**  
(Month) (Day) (Year)

8. AGE: Years **80** Months **7** Days **27** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Maywood Community, Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

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

MOTHER FATHER  
12. Name **Herman, Hoffman**  
13. Birthplace **Zenknoben**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Leanna Hurst**

(b) Address **Durham, Mo**

17. (a) **Burial** (b) Date **19 1945**  
(Burial, cremation, or removal) (Day) (Year)

(c) Place: burial or cremation **Mt. Sinai**

18. (a) Signature of funeral director **Chambers**

(b) Address **Marion, Mo**

19. (a) **12-19-45** (b) **Boone**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Marion 64**  
(c) City or town **Durham Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **574 S.W. Durham**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **17**  
year **1945** hour **2** minute **30 P.M.**  
21. I hereby certify that I attended the deceased from **Dec 14**, 1945 to **Dec 17**, 1945;  
that I last saw him alive on **Dec 17**, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **24.15**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Senility** **years**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy **no** **100**

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 **Larry J. M. Brockm** (M. D. or other) **MD**  
Address **La Belle Mo** Date signed **Dec 18**

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

100625

**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. Chambers

9 Licensed Embalmer No. 3766

P. O. Address Maywood, Ill.

**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.**