V. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1767

Registration District No. 207 Primary Registration District No. 5756 Registrar's No. 2

1. PLACE OF DEATH:

(a) County Maries

(b) City or town Rural - Belle
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community entire life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries 6

(c) City or town Rural = Belle
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Cynthia Ellen Peters

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Female

5. Color or race White

6. (a) ~~Single, widowed,~~ married, ~~divorced~~ Married

6. (b) Name of husband ~~or wife~~ Thomas Peters

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Feb (Month) 14 (Day) 1884 (Year)

8. AGE: Years 62 Months 10 Days 22 If less than one day hr. min.

9. Birthplace Maries County Mo. (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Jacob West
13. Birthplace Franklin County Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Geister
15. Birthplace Maries County Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Thomas Peters
(b) Address Belle - Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8-46 (Month) (Day) (Year)
(c) Place: burial or cremation Highgate

18. (a) Signature of funeral director Sparmann's Funeral Service
(b) Address Belle Mo

19. (a) 1-13-47 (Date received local registrar) (b) Pauline Howard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1947 hour 9 minute A M.

21. I hereby certify that I attended the deceased from
1 Jan 1940, to Jan 6, 1947;
that I last saw her alive on Jan 5, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Brain Tumor unspecified	3 yrs
Chronic Myocarditis	4 yrs
Due to Chronic Nephritis	5 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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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? 2

23. Signature R. H. Schoenhals (Date signed)

Address Belle, Mo Date signed 1/10/47

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 1-21-47

JAN 29 1947

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 Chester Sassmann

Licensed Embalmer No. 7178

P. O. Address Bland - 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.