S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 27 1947

Registration District No. B 17

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3445

Primary Registration District No. 6076

Registrar's No. 110

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Airport Rd At Berkley Dr
(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 St. Louis 96

(c) City or town Berkley
(If outside city or town limits, write "RURAL")

(d) Street No. Airport Rd At Berkley Dr
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Larry Joseph Peistrup

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife .....

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

7. Birth date of deceased 9/17/1946 (Month) (Day) (Year)

8. AGE: Years | Months 3 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace St. Louis (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Child

11. Industry or business .....

FATHER
12. Name John Peister
13. Birthplace St. Louis (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Norma J Douglas
15. Birthplace Marbel Hill (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant John Peister
(b) Address Airport Rd At Berkley Dr

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Robert J. Ambruster Inc
(b) Address 6633 Clayton Road

19. (a) 1-20-47 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature) MSC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16th
year 1947 hour 2.25 minute A M.

21. I hereby certify that I attended the deceased from 1/14/47, 19..., to 1/16/47, 19...;
that I last saw him alive on 1/16/47, 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory Failure - central in origin	30 hrs
Due to congenital hydrocephalus - internal type	4 mos.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

157A

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury 0

23. Signature Joseph D Judy (M. D. or other) MD
Address 9a South Florrisant Rd Date signed 1/17/47

(Licensed Embalmer's Statement on Reverse Side)

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.