

No. 2
-12-45
-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 8 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15979**
Registrar's No. **1003**

Registration District No. _____ Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis** **ST. LOUIS**
 (b) City or town **Rural**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Hosp Koel Hosp O.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **30 days**
 (Specify whether _____)

In this community _____
 years, months or days

3. (a) PRINT FULL NAME **VESTER PETER**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **FEM** 5. Color or race **C**
 6. (a) Single, widowed, married, divorced **Separated**
 6. (b) Name of husband or wife **Wm La Peter** 6. (c) Age of husband or wife if alive **?** years
 7. Birth date of deceased **12 - 15 - 26**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	20	4	15	hr. min.

9. Birthplace **Shugualak** **Miss**
(City, town, or county) (State or foreign country)

10. Usual occupation **MAID**

11. Industry or business _____

12. Name **Sylvester MARSHALL** **g**

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name **GRACEY TERRY**

15. Birthplace **Shugualak** **Miss**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record of A**

(b) Address _____

17. (a) **Removal** (b) Date thereof **5-3-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Shugualak**

18. (a) Signature of funeral director **W. M. ...**
(b) Address **3512 ...**

19. (a) **5-6-47** (b) **Coel ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **...**
 (c) City or town **St. Louis** **17**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2826 Delmar** **9**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **30**
 year **1947** hour **6** minute **30** P. M.
 21. I hereby certify that I attended the deceased from **3-11-1947** to **4-30-1947**
 that I last saw him alive on **4-30-1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberc. Ibe. F.A. T** Duration **7 mo**

Due to **138**

Other conditions **Ibe Laryngitis**

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?

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

23. Signature **John T. ...** (M. D. or other) **1/1/47**
Address **Hosp Koel Hosp** Date signed **5/1/47**

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

MOTHER FATHER

MAY 16 1952

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.....

P. M. Green

Licensed Embalmer No. 1175

P. O. Address 3517 Soledad

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.