

FILED JUL 26 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

Primary Registration District No.

State File No. 25926

Registrar's No. 6842

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **City St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmary Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... **6-6-47-7-20-47**
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME..... **William Peeples**
3. (b) If veteran, name was.....
3. (c) Social Security No.

4. Sex..... **Male** 5. Color or race..... **White**
6. (a) Single, widowed, married, divorced..... **Divorced**
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... **NOV 6 1870**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 8 14 hr. min.

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

10. Usual occupation..... **Millright**

11. Industry or business.....

12. Name..... **Henry Peeples**

13. Birthplace..... **Pittsburg Pa.**
(City, town, or county) (State or foreign country)

14. Maiden name..... **Cath. Meyers**

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

16. (a) Informant..... **City Infirmary Hospital**

(b) Address..... **5800 Arsenal St.**

17. (a) **Cremation** (b) Date thereof..... **7/21/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Valhalla Crematory**

18. (a) Signature of funeral director..... **Albert H. Hoppe**

(b) Address..... **4700 Washington Blvd.**

19. (a) **JUL 21 1947** (b) **J. F. Prosser**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County.....
(c) City or town..... **City**
(If outside city or town limits, write "RURAL")
(d) Street No..... **5800 Arsenal St.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **7** day..... **20**
year..... **1947** hour..... **11:5** minute..... **15** A. M.
21. I hereby certify that I attended the deceased from..... **6**
6 19**44** to **7** -**20** 19**47**;
that I last saw him alive on..... **7-20** 19**47**;
and that death occurred on the date and hour stated above.
Immediate cause of death..... **Uremia**
Duration..... **132**

Due to..... **Chronic interstitial nephritis & multiple infarcts (old)** 131a

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause of 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.....

23. Signature..... **Waver C. Deuren** D. or O. M. D.

Address..... **5800 Arsenal** Date signed..... **7-21-47**

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

MOTHER FATHER

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..... **NO EMBALM**

• Licensed Embalmer No.....

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.