No. 2
-1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

7426

State File No. .....

FILED FEB 24 1948

Registration District No. 1487

Primary Registration District No. 6076

Registrar's No. 387

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Pine Crest Homes 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 months (Specify whether
In this community 6 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Ballwin 0
(If outside city or town limits, write "RURAL")

(d) Street No. Manchester Rd. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME Elizabeth Peters

3. (b) If veteran, name war No.

3. (c) Social Security No. unknown

4. Sex Female 1

5. Color or race W.

6. (a) Single, widowed, married, divorced widowed 2

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

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

7. Birth date of deceased Aug (Month) 27 (Day) 1871 (Year)

8. AGE:

Years	Months	Days	If less than one day
76	5	7	..... hr. ..... min.

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

10. Usual occupation unknown

11. Industry or business "

FATHER
12. Name Philip Vogel 4
13. Birthplace Germany (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name Unknown 1
15. Birthplace Germany (City, town, or county) (State or foreign country) 4

16. (a) Informant Rose Schatz
(b) Address 1519 Destrehan - St Louis Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-48 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Robert J. Ambruster, Inc.
(b) Address Clayton Rd. at Concordia Lane

19. (a) 2-7-48 (Date received local registrar) (b) Cecil R. J. Sharp MD (Registrar's signature) HSA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Quarter day 3
year 1948 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 28th, 1947, to February 3, 1948
that I last saw her alive on February 2, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to .....

Due to 93d

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

Major findings:
Of operations .....

Of autopsy .....

Duration

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 R. N. Jausens (M. D. ~~or other~~)

Address Manchester Mo Date signed 2/5/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

FEB 24 1948

FEB 25 1948

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.