

FILED MAR 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3907

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

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>60</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Ralls</u> <u>07</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (In this place) <u>16 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Clay township</u> <u>0</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>K.C.O.S Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>R. R. # 4, Hannibal, Mo.</u> <u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Dwight</u> b. (Middle) <u>Leroy</u> c. (Last) <u>Peters</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2 - 17 - 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 16, 1906</u>	
9. AGE (In years last birthday) <u>42</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>St. Charles, Iowa</u> <u>1</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13a. FATHER'S NAME <u>Otis L. Peters</u>		13b. MOTHER'S MAIDEN NAME <u>Hattie Roberts</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Elizabeth Peters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Elizabeth Peters, R. #4, Hannibal</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Circulatory collapse</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive heart disease</u> <u>2 years</u> DUE TO (c) <u>Chronic nephritis</u> <u>2 years?</u> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>2 years</u> <u>2 years?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>5/27</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1</u> , 19 <u>49</u> , to <u>Feb 17</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>49</u> , and that death occurred at <u>4:55 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M. T. Lutenshu D.O. 2, Kirksville, Mo</u>				23b. ADDRESS <u>Kirksville, Mo</u>		23c. DATE SIGNED <u>2-17-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 20 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hydesburg Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Ralls county Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-23-49</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. Harris</u>		ADDRESS <u>Kirksville, Mo</u>	

BACK OF 704

RECEIVED

District Health Officer No. 10

District File Number 2-49-38

Date Filed FEB 28 1949

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kidsville, 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.