

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6554

State File No. ....

1153

FILED FEB 23 1949

BIRTH NO. 48-78320 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Cape Girardeau</u>	
c. LENGTH OF STAY (In this place) <u>1 Day</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Missouri Baptist Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Judith</u>		b. (Middle) <u>ANN</u>	
c. (Last) <u>Peters</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-4-1949</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>S</u>	8. DATE OF BIRTH <u>Dec 9 1948</u>
9. AGE (In years last birthday) <u>1</u> Months <u>1</u> Days <u>25</u> Hours <u></u> Min.		11. BIRTHPLACE (State or foreign country) <u>MO</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas F. Peters</u>	
13b. MOTHER'S MAIDEN NAME <u>Violet L. Davis</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Thomas F. Peters Cape Girardeau Mo.</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Spina Bifida &amp; Hydrocephalus Congenital</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>a</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>1927</u> <u>1930</u> <u>1932</u> Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) m.		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>Dec 20, 1948</u> to <u>Feb 4, 1949</u> , that I last saw the deceased alive on <u>Feb 4, 1949</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>J. W. White W.D. (I)</u>		23b. ADDRESS <u>Lister Bldg. 4500 Olive St.</u>	
23c. DATE SIGNED <u>Feb 4/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb 4 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Fairmount</u>		24d. LOCATION (City, town, or county) (State) <u>Cape Girardeau Mo.</u>	
DATE REC'D BY LOCAL REG. <u>FEB 7 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Sasser</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Haman Funeral Home</u>		ADDRESS <u>Cape Girardeau Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

M.R.

no.

1153

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 \_\_\_\_\_

*NOT Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*John M. Simeon*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*4343*

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.