

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35744

| | | | | | | | |
|---|---------------------------|---|---|---|--|---|-----------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. <u>317</u> | | PRIMARY REG. DIST. NO. <u>3263</u> | | Registrar's No. <u>4067</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON</u> | | c. LENGTH OF STAY (in this place) <u>6 DAYS</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES</u> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST LOUIS CO. HOSPITAL</u> | | | | d. STREET ADDRESS (If rural, give location) <u>323 W PACIFIC</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>VIOLA</u> b. (Middle) <u>MAY</u> c. (Last) <u>PETERSON</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 2 1949</u> | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>SEPT 4. 1874</u> | 9. AGE (In years last birthday) <u>75</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>MARIES CO. MO.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13a. FATHER'S NAME <u>THOMAS BROWN</u> | | | 13b. MOTHER'S MAIDEN NAME <u>MARGARET DICKEY</u> | | 14. NAME OF HUSBAND OR WIFE <u>JOHN PETERSON</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mildred Mehl</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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congrene lower Extremities Bilateral</u> <u>External Iliac Artery Thrombosis Bilateral</u> ANTECEDENT CAUSES <u>Fractured</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> II. OTHER SIGNIFICANT CONDITIONS <u>Diabetes Mellitus</u> Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>10 years</u> | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION <u>443 X</u> | | | 20. AUTOPSY? YES <input checked="" 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) <u>443 X</u> | | | |
| 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? <u>443 X</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>9-28th</u> , 19 <u>49</u> , to <u>10-2</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10-2</u> , 19 <u>49</u> , and that death occurred at <u>6:35 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Henry K. Telling M.D.</u> | | | | 23b. ADDRESS <u>St. Louis Co Hospital</u> | | 23c. DATE SIGNED <u>10-2-49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>OCT 5 1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u> | | 24d. LOCATION (City, town, or county) (State) <u>KIRKWOOD MO</u> | |
| DATE REC'D BY LOCAL REG. <u>10-4-49</u> | | REGISTRAR'S SIGNATURE <u>Herbert R. Monke, M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Groves Mo</u> | | | |

65-9M

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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Whiter Groves*

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.