

FILED OCT 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30035

0396
OK D

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 869

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY Greene <i>n 396</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hosp.		d. STREET ADDRESS (If rural, give location) 2211 N. Pierce	
3. NAME OF DECEASED a. (First) Francis b. (Middle) R. c. (Last) Peakin			4. DATE OF DEATH (Month) (Day) (Year) Sept Oct. 3, 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 4 1874
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Iowa /
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE X	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME Joseph Golightley ADDRESS Springfield, Mo.
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probably Hodgkins disease INTERVAL BETWEEN ONSET AND DEATH not known II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 2017 UNATTENDED BY A PHYSICIAN	
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) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE W.E. Handley		23b. ADDRESS Local Registrar of Vital Statistics 8 City Hall, Springfield, Mo.	
23c. DATE SIGNED 10/5-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/6/50	
24c. NAME OF CEMETERY OR CREMATORY St. Mary		24d. LOCATION (City, town, or county) Springfield, Mo.	
DATE REC'D BY LOCAL REG. 10-5-50		REGISTRAR'S SIGNATURE W.E. Handley WJD	
25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer		ADDRESS Springfield, Mo.	

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

OCT 20 1950

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 Walter E Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield, 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.