

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31855
8002

State File No. _____
Registrar's No. _____

FILED OCT 5 1950

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN <u>St. Louis</u>		a. STATE <u>Illinois</u>	b. COUNTY <u>Christian</u>
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Taylorville</u> <u>8120</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>605 W. 2nd St.</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) <u>Fritz</u>	b. (Middle) <u>C.</u>	c. (Last) <u>Peters</u>	<u>Sept. 21, 1950</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>March 15, 1884</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Godfrey Peters</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Johanson</u>	14. NAME OF HUSBAND OR WIFE <u>Ella</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Julius Peters, Butte, Montana</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Subarachnoid Hemorrhage</u>		ANTECEDENT CAUSES <u>following accident in July 1950 near or in Decatur Ill. (exact time place and manner of same could not be determined)</u>		
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <u>1950 near or in Decatur Ill. (exact time place and manner of same could not be determined)</u>		
		DUE TO (c) <u>not be determined</u>		
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Open Fracture: 812</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Verdict</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>812</u>
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? <u>812</u>

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 10:55 P.m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <u>Patrick E Taylor 3 Coroner</u>		23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>9-21-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>9-22-50</u>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <u>Taylorville, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>SEP 21 1950</u>	REGISTRAR'S SIGNATURE <u>J B Laster</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>		

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....

Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.