No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39570

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9920

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 21 19
d. STREET ADDRESS (If rural, give location): 3634 Aldine

3. NAME OF DECEASED (Type or Print)
a. (First): Melba
b. (Middle):
c. (Last): Peters

4. DATE OF DEATH (Month) 11 (Day) 7 (Year) 51

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 27, 1914
9. AGE (In years last birthday): 37
If under 1 year: Months / Days
If under 1 day: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gypsy, Missouri D
12. CITIZEN OF WHAT COUNTRY? U S

13a. FATHER'S NAME: D.W. YOUNG
13b. MOTHER'S MAIDEN NAME: Ora Atchison
14. NAME OF HUSBAND OR WIFE: William Peters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME: William Peters
ADDRESS: 3634 Aldine

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) Acute Coronary thrombosis.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Cholecystitis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 11-7-51
19b. MAJOR FINDINGS OF OPERATION: Chronic Cholecystitis
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 585X

22. *I hereby certify that I attended the deceased from* Jan - 15, 1951, *to* Nov 7, 1951, *that I last saw the deceased alive on* Nov 7, 1951, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Lloyd L Reid (Degree or title) MD
23b. ADDRESS: 8239 N Grand St Louis Mo
23c. DATE SIGNED: 11-9-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 11-8-51
24c. NAME OF CEMETERY OR CREMATORY: Jamison
24d. LOCATION (City, town, or county) (State): Advance, Missouri

DATE REC'D BY LOCAL REG. NOV 9 1951
REGISTRAR'S SIGNATURE: Earl Smith M.D. K.P.
25. FUNERAL DIRECTOR'S SIGNATURE: Albert H. Hoppe
ADDRESS: 4700 Washington

(Licensed Embalmer's Statement on Reverse Side)

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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed John J. Haines

Licensed Embalmer No. 4108

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.