

41764

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 7791-5187

No. 300
10.48

FILED JAN 2 1953

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 5220

190
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Rural, 1 Mi East Lisle Mo.		c. LENGTH OF STAY (in this place) OR TOWN Rural, Coldwater Twp.	
d. FULL NAME OF HOSPITAL OR INSTITUTION At home. Not in Hosp.		d. STREET ADDRESS (If rural: give location) Lisle, Mo. Route 1.	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES		b. (Middle) WILLIAM	
c. (Last) PEFFER.		4. DATE OF DEATH (Month) (Day) (Year) 12 20 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 17, 1881
9. AGE (In years last birthday) 71	IF UNDER 1 YEAR (Months) (Day) 4 2	IF UNDER 1 HR. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ry Water Service, K.C.S Ry.		10b. KIND OF BUSINESS OR INDUSTRY Retired.	
11. BIRTHPLACE (State or foreign country) South Bend, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Theodore A. Peffer		13b. MOTHER'S MAIDEN NAME Nellie Glover.	
14. NAME OF HUSBAND OR WIFE Lena Hall Peffer.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No.		16. SOCIAL SECURITY NO. None.	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Lena Peffer,		ADDRESS Lisle, Missouri	
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) Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) Hypertension. DUE TO (c) Arterio Sclerosis 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 331X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 Dec. 14, 1952 to Dec. 19, 1952 , that I last saw the deceased alive on Dec. 18, 1952 , and that death occurred at 8:00 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Basil C. Hartwell		23b. ADDRESS (Degree or title) M.D. Drexel, Missouri.	
23c. DATE SIGNED 12/20/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/22/52.	
24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24d. LOCATION (City, town, or county) (State) Independence, Mo. Drexel, Mo.	
DATE REC'D BY LOCAL REG. 12/23/52		REGISTRAR'S SIGNATURE Nora Barward	
FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Drexel, Mo.	

(Licensed Embalmers' Signature on Reverse Side)

APR 20 1953

FEB 20 1953

RECEIVED
DEC 27
CASS COUNTY
HEALTH DEPARTMENT

MAY 5 1957

STATEMENT BY LICENSED EMBALMER

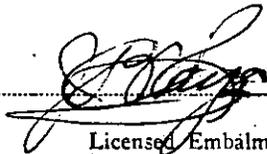
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~XXXX~~

~~XXXXXXXXXXXX~~

working under ~~XXXX personal supervision~~

Student ~~XXXXXXXXXXXX~~
Student Embalmer

Signed



Licensed Embalmer No. 1950

P. O. Address Drexel, 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.