

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12141

State File No. ....

3036

FILED APR 4 1953

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. ....

1. PLACE OF DEATH a. COUNTY  b. CITY (If outside corporate limits, write RURAL and give OR TOWN) ST. LOUIS  c. LENGTH OF STAY (in this place)  d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mississippi b. COUNTY  c. CITY (If outside corporate limits, write RURAL and give township): Cleveland 8230  d. STREET ADDRESS (If rural, give location) Route #1	
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) NMN c. (Last) PEOPLES		4. DATE OF DEATH (Month) (Day) (Year) 3 18 53	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-17-1893
9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months 8	IF UNDER 1 YEAR Days 2	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State, or Foreign Country) Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Lee Peoples		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Della Mae Peoples
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Johnnie James 1911 s O'Fallon
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) Respiratory arrest  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Emphysema  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		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)	
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? 518x	
22. I hereby certify that I attended the deceased from 3-16, 1953, to 3-18, 1953, that I last saw the deceased alive on 3-18, 1953, and that death occurred at 9:35 a.m., from the causes and on the date stated above.			
23a. SIGNATURE FR Bradley		23b. ADDRESS (Degree or title) M.D. BARNES HOSPITAL	23c. DATE SIGNED 3-18-53
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 3-21-53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Cleveland, Mississippi
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 20 1953 J.C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.		

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 Fulton E. Calkin

Licensed Embalmer No. 4198

P. O. Address St. Louis 13, 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.