

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20530**

FILED MAY 23 1953

BIRTH NO. _____		REG. DIST. NO. <b>367</b>		PRIMARY REG. DIST. NO. <b>4531</b>		Registrar's No. <b>176</b>	
1. PLACE OF DEATH a. COUNTY <b>WARREN</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CELLEWAY</b>			
b. CITY OR TOWN <b>WARRENTON</b>		c. LENGTH OF STAY (in this place) <b>9 Mos.</b>		c. CITY OR TOWN <b>WILLIAMS BURG</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>KATIE JANE MEM. HOME</b>				e. STREET ADDRESS (If rural, give location) <b>0140</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>NETTIE</b>		b. (Middle) <b>C.</b>		c. (Last) <b>PETERS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 7, 1953</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>JAN 1, 1864</b>	
9. AGE (In years last birthday) <b>89</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>PORTLAND Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>CHARLES ARNOLD</b>		13b. MOTHER'S MAIDEN NAME <b>CAROLINE SCHOLL</b>		14. NAME OF HUSBAND OR WIFE <b>JOHN T. PETERS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>1X0</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>JOHN A WEEKS WILLIAMSBURG Mo</b>			
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) <b>Carcinoma of the bladder</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Infirmities of old age</b> 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 <b>Don't Know</b> <b>20 yrs</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>181X</b>				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 <b>May 29, 1953</b> , to <b>May 7, 1953</b> , that I last saw the deceased alive on <b>May 7, 1953</b> , and that death occurred at <b>4 P. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>John H. Ayer, M.D.</b>				23b. ADDRESS <b>Warrenton Mo</b>		23c. DATE SIGNED <b>5-8-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>5/9/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ANTILOCK Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>CELLEWAY COUNTY, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>5-8-53</b>		REGISTRAR'S SIGNATURE <b>Floyd Logan</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>MAUPIN Funeral Home, FULTON Mo</b>			

(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.....  
Signature of Student Embalmer

Signed *Nancy A. Stewart*.....

Licensed Embalmer No. *372*.....

P. O. Address *Frederick*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.