

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 28965

Registrar's No. 6866

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4444 West Belle Pl.				STREET ADDRESS (If rural, give location) 4444 West Belle Place 21190			
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT		b. (Middle) W.		c. (Last) PETERS		4. DATE OF DEATH (Month) (Day) (Year) July 20 1956	
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug 3 1896	
9. AGE (in years last birthday) 59		IF UNDER 1 YEAR Months 11 Days 17		IF UNDER 24 HRS. Hours 11 Min. 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Furniture Moving		11. BIRTHPLACE (City and State or Foreign Country) / Dickson Tenn		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME J.A. Peters		13b. MOTHER'S MAIDEN NAME Dollie Hornbeak		14. NAME OF HUSBAND OR WIFE Lucy Peters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 1		16. SOCIAL SECURITY NO. 329-10-2151		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lucy Peters 4444 West Belle Pl			
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) Cortic Insufficiency ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 42-11				INTERVAL BETWEEN ONSET AND DEATH 1955	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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? 42-11			
22. I, hereby certify that I attended the deceased from May 2 1956 , to July 20 1956 , that I last saw the deceased alive on July 20 1956 , and that death occurred at 4:20 p.m. from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) James T. Aldrich M.D.				23b. ADDRESS 26212 Franklin Ave			
23c. DATE SIGNED July 21-56		23d. NAME OF CEMETERY OR CREMATORY National		23e. LOCATION (City, town, or county) (State) Jefferson Barracks Mo			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 24 1956		24c. NAME OF FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Bell Ave			
DATE REC'D BY LOCAL REG. JUL 23 1956		REGISTRAR'S SIGNATURE J. Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Bell Ave			

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 *Ester K. Harris*

Licensed Embalmer No. *44*

P. O. Address *4181 W...*

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.