

FILED APR 15 1957

## STANDARD CERTIFICATE OF DEATH

11086

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3115

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If instant: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY                                     |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>ST. LOUIS Mo</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                   |   | c. CITY<br>OR<br>TOWN <u>ST. LOUIS</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 5021-CHIPPEWA</u>   |  |   |   | Length of stay in lb<br><u>21480</u>  |  | d. STREET ADDRESS (If outside, give location) <u>5021-CHIPPEWA</u>        |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>PETER</u> Middle <u>M.</u> Last <u>SILVER</u>   |  |   |   | 4. DATE OF DEATH<br>Month <u>MAR.</u> Day <u>30</u> Year <u>1967</u>  |  |   |  |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>MAR. 5 1893</u>                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bookkeeper</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>New St. Marcus</u>  |   | 11. BIRTHPLACE (City and state or country)<br><u>Missouri</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                             |  |
| 13. FATHER'S NAME<br><u>Peter M. Silver</u>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>MATHILDA MAUGH</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>488-09-1581</u>   |   | 17. INFORMANT Address<br><u>ROMANA SILVER 5021-CHIPPEWA</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br><u>Arteriosclerotic heart disease</u><br>DUE TO (b) <u>arterio-sclerotic heart disease</u><br>DUE TO (c) <u>disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes mellitus</u> |  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>3 y.t.</u>        |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>No</u> |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____ Year _____<br>a. m. _____ p. m. _____   |  |   | 4200  |   |  |   |  |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><u>1-15-56</u> |   | 20f. CITY, TOWN, OR LOCATION<br><u>3-30-57</u>  |  | COUNTY<br><u>3-29-57</u>  |  |
| 21. I attended the deceased from <u>Jan 5-57 to Jan 30-57</u> and last saw <u>her</u> alive on <u>3-29-57</u><br>Death occurred at <u>3:30 AM</u> on the date stated above; and to the best of my knowledge, from the cause stated.   |  |   |   |   |  |   |  |
| 22a. SIGNATURE<br><u>Jos. Davie</u> (Degree or title) <u>M.D.</u>   |  |   |   | 22b. ADDRESS<br><u>906 Olive St.</u>  |  | 22c. DATE SIGNED<br><u>3-30-57</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><u>Apr. 2 1957</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New St. Marcus Cem.</u>  |  | 23d. LOCATION (City, town, or county) (State)<br><u>ST. LOUIS Mo</u>      |  |
| 24. FUNERAL DIRECTOR<br><u>Thomas Kute 2906 Gravois</u>   |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><u>APR 1 - '57</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith Mo</u>                         |  |

(Licensed Embalmer's Statement on Reverse Side)

Health,  
& Welfare  
Public  
ServiceS. 300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

Bo-1-1276

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Mona

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 *Les J. Budde*

Licensed Embalmer No. 398

P. O. Address *St. Louis*

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.