

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 30 1957

233

4348 State File No. 14033

BIRTH NO. _____		REG. DIST. NO. 4348		PRIMARY REG. DIST. NO. 233		Registrar's No. 8	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>WELLSVILLE</b>		c. LENGTH OF STAY (In this place) <b>19 YRS</b>		c. CITY OR TOWN <b>WELLSVILLE</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>200 E. HUDSON</b>				f. STREET ADDRESS (If rural, give location) <b>200 East Hudson</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>IRA</b> b. (Middle) <b>T.</b> c. (Last) <b>PEYTON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 19 - 1957</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>JUNE 14 - 1890</b>	
9. AGE (In years last birthday) <b>66</b>		10. MONTHS <b>10</b>		11. DAYS <b>5</b>		12. IF UNDER 1 YEAR Hours Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DRUG</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>MISSOURI</b>	
13a. FATHER'S NAME <b>Chas T. Peyton</b>		13b. MOTHER'S MAIDEN NAME <b>Jeanne Nelson</b>		14. NAME OF HUSBAND OR WIFE <b>CAUSTA PEYTON</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>495-36-1928</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MRS. I. T. PEYTON WELLSVILLE - 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>Coronary thrombosis</b>  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.					INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <b>2</b> 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) (Min.)		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>4/19, 1957</b> , to <b>4/19, 1957</b> , that I last saw the deceased alive on <b>4/19, 1957</b> , and that death occurred at <b>4 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Willis H. Wells MD</b>				23b. ADDRESS <b>Wellsville Mo</b>		23c. DATE SIGNED <b>4-20-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>4-20-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>WELLSVILLE CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>WELLSVILLE - MO</b>	
DATE REC'D BY LOCAL REG. <b>4-21-57</b>		REGISTRAR'S SIGNATURE <b>Mrs. Antoinette Romano</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. B. Wells Wellsville Mo</b>			

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

JUN 20 1957

DEC 6 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, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Richard T. Donald*.....

Licensed Embalmer No. *7825*

P. O. Address *Memphis*.....

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.