

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030085

STATE FILE NUMBER

FILED SEP 9 1958 Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 332

Health,  
Welfare  
Public  
Service

300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Francois</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Pemiscot</b>                 |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWNSHIP <b>St. Francois Township</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>      |  | c. CITY<br>OR<br>TOWNSHIP <b>6180 OR TOWN CARROLL Nearle Hayti</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>State Hospital No. 419y, 13d</b>   |  |   | Length of stay in 1b<br><b>19y, 13d</b>  |   |  | d. STREET (If outside, give location)<br>ADDRESS <b>County Farm.</b>                 |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SAM</b> Middle <b>BIDWELL</b> Last <b>PETERSON</b>  |  |   |  | 4. DATE OF DEATH <b>August 4, 1958</b><br>Month <b>August</b> Day <b>4</b> Year <b>1958</b>   |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>abt. 1894 (unknown)</b>                                       |  |
| 9. AGE (In years last birthday) <b>Abt. 64</b>  |  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>6</b> Hours <b>4</b> Min.                      |  | 11. BIRTHPLACE (City and state or country)<br><b>Tennessee</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>farmer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)   |  |
| 13. FATHER'S NAME<br><b>unknown</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br><b>Records, State Hospital No. 4, Farmington</b>      |  |  |
| 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) <b>Coronary Occlusion</b> - - - - - <b>Abt. 6 hrs.</b><br><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b> = = = = = <b>Unknown.</b><br>DUE TO (c) <b>4200</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Psychosis with mental deficiency.</b>   |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>  |  |   |  |   |  |  |  |
| 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.) |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour <b>2:15</b> Month, Day, Year<br>a. m. <b>A. M.</b><br>p. m.   |  |   |  |   |  |  |  |
| 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.) |  | 20f. CITY, TOWN, OR LOCATION<br><b>Farmington, Missouri</b>   |  | 20g. COUNTY  |  |
| 21. I attended the deceased from <b>Aug. 3, 1958</b> to <b>Aug. 4, 1958</b> and last saw <sup>him</sup> <b>him</b> alive on <b>Aug. 4, 1958</b><br>Death occurred at <b>2:15 A. M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>John A. Brennan, M.D.</b> (Degree or title)  |  |   |  | 22b. ADDRESS<br><b>State Hospital No. 4 Farmington, Missouri</b>  |  | 22c. DATE SIGNED<br><b>8-4-58</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE<br><b>Aug. 6, 1958</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Univ. Anat. Dept.</b>                    |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Cozean Funeral Home, Farmington, Mo.</b>   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>Aug. 4, 1958</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>C Esther Rudloff</b>                   |  |  |

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..

NOT EMBALMED

NOT EMBALMED

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.