

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034585
STATE FILE NUMBER
REGISTRAR'S NO. 9028

FILED OCT 3, 1958 Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If outside, give location) 6041 Waterman Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Rose Peck		4. DATE OF DEATH Month Day Year Sept. 16, 1958	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-at home		11. BIRTHPLACE (City and state or country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Jacob Gross		13b. MOTHER'S MAIDEN NAME Eliza White	14. NAME OF HUSBAND OR WIFE James C. Peck
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mr. Robert Peck, 6041 Waterman Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage Trauma of a fall Conditions may be due to (b) Trauma of a fall which may be due to (c) Trauma of a fall stating the underlying cause lost. 9/11/58 E903.0 20		INTERVAL BETWEEN ONSET AND DEATH 9-11-58
PART II. OTHER PROMINENT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) Fell on rug in her own home striking her head	
20c. TIME OF INJURY Hour Month, Day, Year 9:30 p.m. 9-11-58	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 5 home	
20e. CITY, TOWN OR LOCATION St. Louis	20f. COUNTY Mo.	20g. STATE
21. I attended the deceased from 1955 to 9-16-58 and last saw her alive on 9-16-58 Death occurred at 5:15 5:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Ann Higgins, M.D.	22b. ADDRESS 634 N. Grand Ave.	22c. DATE SIGNED 9-18-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 19, 1958	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis, Missouri		(State)
24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. SFP 18'58
26. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-57

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 *Wm S Sage*
Licensed Embalmer No. *4699*
P. O. Address *3840 Linden*

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.