

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002606
STATE FILE NUMBER

JAN FEB 9 1959 Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 6

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rural- Collins</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Hospt;</u>			Length of stay in 1b <u>8 days</u>		d. STREET ADDRESS (If outside, give location) <u>3 Miles W- Collins</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Bertram</u> Middle <u>C.</u> Last <u>Peterie</u>				4. DATE OF DEATH Month <u>Jan</u> ; Day <u>26</u> ; Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan; 26, 1876</u>		9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Maxie Peterie</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Durl Peterie, Collins</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, hypostatic</u>							INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>arteriosclerotic heart disease & decompensation</u>					7 days		
		DUE TO (c) <u>Coronary artery disease</u>					years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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		COUNTY		STATE	
21. I attended the deceased from <u>18 Jun 1959</u> to <u>26 Jan 1959</u> and last saw him alive on <u>26 Jun 1959</u> Death occurred at <u>11:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>D. H. Lester M.D.</u> (Degree or title)				22b. ADDRESS <u>Osceola Mo</u>				22c. DATE SIGNED <u>27 Jun 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>1/29/59</u>		<u>Freeman</u>			<u>Collins Mo</u>		
24. FUNERAL DIRECTOR <u>Goodrich Home Care Co</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>1-28-1959</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>			

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Paul J. J. J.*

Licensed Embalmer No. *3990*
P. O. Address *Acme, Md.*

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.