

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015536

FILED APR 24 1959

STATE FILING NUMBER
23441

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS 2010 Franklin	
3. NAME OF DECEASED (Type or print) First Middle Last Anthony Peters		4. DATE OF DEATH Month Day Year 4-5-59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Carl Peters		13b. MOTHER'S MAIDEN NAME Mary Roach	12. CITIZEN OF WHAT COUNTRY? USA
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. 497-10-4208	17. INFORMANT Address Ottilia Hacker 4931 Thekla 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) <i>Metastatic Carcinomatosis</i>			INTERVAL BETWEEN ONSET AND DEATH 10 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>Hypertrophied Left Kidney</i>			5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 180X			WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 COUNTY STATE	
21. I attended the deceased from 5-19-58 to 4-5-59 and last saw her alive on 4-5-59 Death occurred at 4:00 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		22b. ADDRESS <i>5800 Arsenal</i>	
		22c. DATE SIGNED 4/6/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Apr 8 1959	
		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR Bromschwig and Son W Florissant		25. DATE RECD. BY LOCAL REG. APR 7 '59	
		26. REGISTERAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Yellow, Public Service, 00, 57, 7, 1944, 0, All diseases in Part I must be causally related.

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 *J. Wm. Ambler*

Licensed Embalmer No. *3657*
P. O. Address *H. P. S.*

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.