

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023271

STATE FILE NUMBER

24856

FILED JUN 19 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>UNIVERSITY CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1529 MOORE PL.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>NOLA E. PEGGS</u>			4. DATE OF DEATH Month Day Year <u>MAY 18, 1959</u>	
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12-1888</u>	9. AGE (In years last birthday) <u>72</u>	FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>WASHINGTON IND.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>DAVID W. TAYLOR</u>	13b. MOTHER'S MAIDEN NAME <u>MARY HORRELL</u>	14. NAME OF HUSBAND OR WIFE <u>JOSEPH W. PEGGS</u>
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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. <u>NONE</u>	17. INFORMANT Address <u>Mrs. CLAUDE WELCH, 721 SWARTHMORE</u>
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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>SUBARACHNOID HEMORRHAGE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ACUTE MONOBLASTIC LEUKEMIA</u>	6 WEEKS
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>GRAM-NEGATIVE SEPTICEMIA. RIGHT UPPER LOBE LOBAR PNEUMONIA</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.) <u>204.2</u>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <u>MAY 1, 1959</u> to <u>MAY 18, 1959</u> and last saw her/him alive on <u>MAY 18, 1959</u> Death occurred at <u>10:45 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Name or title) <u>C. E. Vermillion, M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>5/19/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBED</u>	23b. DATE <u>MAY 20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL MAUS.</u>	23d. LOCATION (City, town, or county) (State) <u>INDIANAPOLIS INDIANA</u>
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24. FUNERAL DIRECTOR ADDRESS <u>C.R. LUTON &amp; SONS 7233 DELMAR Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 19 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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

MAY 21 1962

EMBALMER CERTIFICATE

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 *Clarence H. Murray*

Licensed Embalmer No. *4018*

P. O. Address *A. Louis Mo*

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.