

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035874**

**FILED VS OCT 26 1959**

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1125

STATE FILE NUMBER

ENDED

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GREENE</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>New York</b> b. COUNTY <b>Erie</b> |  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Springfield</b>  |  |   | Length of stay in 1b<br><b>30 days</b>   |   | c. CITY OR TOWN <b>Buffalo</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Medical Center for Federal Prisoners</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>812 Jefferson St.</b>          |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Love</b> Middle <b>XXXX</b> Last <b>PEELER</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>19</b> Year <b>1959</b>  |  |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</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>10/4/24</b>   | 9. AGE (last birthday)<br><b>35</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HR   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>                          |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Contractor</b>                               |   | 11. BIRTHPLACE (City, and state or country)<br><b>N. Carolina Cleveland County</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>John Peeler</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Ada Weells</b>                                       |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>None</b>           |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes 4/5/43 - 2/8/46</b> |  |   | 16. SOCIAL SECURITY NO.<br><b>069-18-8267</b>  |   | 17. INFORMANT<br><b>MCFP - Files - Springfield, Missouri</b>                       |  |  | Address  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                               |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (a) <b>Asphyxia, due to respiratory obstruction</b>  |  |   |  |   |  |  | <b>3 days</b>  |  |
| DUE TO (b) <b>Squamous cell carcinoma of the bronchia</b>  |  |   |  |   |  |  | <b>Months</b>  |  |
| DUE TO (c)   |  |   |  |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)      |  |   |  |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year  |  |   |  |   |  |  |  |  |
| 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 <b>9/18/59</b> to <b>10/19/59</b> and last saw her/him alive on <b>10/19/59</b>                       |  |   |  | Death occurred at <b>12:04 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                  |  |  |  |  |
| 22. SIGNATURE<br><b>Clarence Koolker, M.D.</b><br>(Doctor or title)<br><b>Medical Director</b>   |  |   | 22b. ADDRESS<br><b>Medical Center for Federal Prisoners - Springfield, Mo.</b>       |   |  | 22c. DATE SIGNED<br><b>10/19 1959</b>                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>10/19/59</b>  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City, town, or county)<br><b>Buffalo, New York</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>AYRE-GOOBWIN SPRINGFIELD, MO.</b>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>10-22-59</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Effie B. Meelton</b> |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 3 1959

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 \_\_\_\_\_  
\_\_\_\_\_

Licensed Embalmer No. 4594

P. O. Address Springfield, M.

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.