MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-027218
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6659

FILED AUG 3 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: De Paul Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Belnor
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 8023 Glen Echo Dr.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Ida Middle: C. Last: Peterson
4. DATE OF DEATH: Month: 7 Day: 21 Year: 61
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/29/81
9. AGE (last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Herman Claus Struss
13b. MOTHER'S MAIDEN NAME: Mathilda Brinkmeyer
14. NAME OF HUSBAND OR WIFE: Albert W. Peterson
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: Harold R. Struss, 1425 Shepley Dr. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary heart disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.1
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 5-12-59 to 7-21-61 and last saw her alive on 7-21-61
Death occurred at 7-21-61 10:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title): MD
22b. ADDRESS: 3720 Washington Blvd
22c. DATE SIGNED: 7-22-61
23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 7/24/61
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
23d. LOCATION (City, town, or county): St. Louis County (State): Mo.
24. FUNERAL DIRECTOR: Drehmann-Harral ADDRESS: 1905 Union
25. DATE RECD. BY LOCAL REG.: JUL 24 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

Beaumont Bldg.
3720 Washington
Je. 1-0136

Hrs. Til 6 PM Fri.
til noon Sat.

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 Warren A. Carve

Licensed Embalmer No. 353x

P. O. Address_____

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.