

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047831

STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. 4226 Registrar's No. 1

FILED JAN 13 1964

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
Rev. 4/59								
1 <u>0440</u>								
2 <u>0440</u>								
3								
4 <u>0</u>								
5 <u>2</u>								
6								
7 <u>0</u>								
8 <u>2</u>								
9 <u>332</u>								
10								
11								
12 <u>902</u>								
13 <u>10</u>								

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Holt</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Corning</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Holt</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Corning, Mo.</u>		Length of stay in 1b <u>80 years</u>		c. CITY OR TOWN <u>Corning</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>*****</u>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Andrew Peters</u>			4. DATE OF DEATH Month Day Year <u>December 31, 1963</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>4/24/1883</u>	
9. AGE (last birthday) <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Merchandise</u>		11. BIRTHPLACE (City and state or country) <u>Corning, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Peters</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Bade</u>		14. NAME OF HUSBAND OR WIFE <u>Rusena M. Peters</u>	
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>[REDACTED]</u>		17. INFORMANT <u>Arnold Peters</u> Address <u>9729 E. 27 Terrace Independence, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>						10 Years	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 a.m. p.m.		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 <u>Jan 24/63</u> to <u>Dec 31/63</u> and last saw ^{her} him alive on <u>Dec 31/63</u> Death occurred at <u>1 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Rusena M. Peters DO</u>				22b. ADDRESS <u>Grand City Mo</u>		22c. DATE SIGNED <u>1/7/64</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 2, 1964</u>		23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>		23d. LOCATION (City, town, or county) (State) <u>Craig, Mo.</u>	
24. FUNERAL DIRECTOR <u>Wilbur L. Schoeder - Craig, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>1-9-1964</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embelmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

1874-1914-1915

DEATH

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 myself _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wilber L. Schoeder _____

Licensed Embalmer No. 3997 _____

P. O. Address Craig, 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.