

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

 PLACE OF DEATH
 County Puckanau
 Township _____
 or _____
 Village _____
 or _____
 City St Joseph (NO. 421 North 15th St. _____ Ward)

 Registration District No. 85 File No. 4247
 Primary Registration District No. 1001 Registered No. 421

[If death occurred in a hospital or institution, give its NAME instead of street and number]

 FULL NAME Henry Coff Perkins

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>March 4th 1841</u> (Month) (Day) (Year)		
AGE <u>70 yrs. 11 mos. 3 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>horse dealer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-111</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Washington Indiana</u>		
PARENTS	NAME OF FATHER <u>John Thompson Perkins</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Betty Perkins</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Virginia</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Sallie Pinner
 (ADDRESS) Adams Neb.

 Filed Feb 7 1912 J. H. Kelling
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

 DATE OF DEATH February 7th 1912
 (Month) (Day) (Year)

 I HEREBY CERTIFY, that I attended deceased from Feb. 1, 1912, to Feb 7, 1912, that I last saw h. l. m. alive on Feb 7, 1912, and that death occurred, on the date stated above, at 10:50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
82A
97 (Duration) yrs. mos. 7 ds.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.

 (Signed) J. J. Bausch M. D.
Feb 7, 1912 (Address) 825 7th Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Lincoln, Neb.
 EMBURY & CO. UND. CO.

 DATE OF BURIAL
Feb 10, 1912

 ADDRESS
227 So. 8th St.

 By J. H. Karle

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Buchanan

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Township _____

Registration District No. 85

File No. 4247

or Village _____

Primary Registration District No. 1001

Registered No. 121

or City Joseph (NO. 421 North 15 St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Henry Cobb Perkins

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH March 4, 1841
(Month) (Day) (Year)

AGE 70 yrs. 11 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION (a) Trade, profession, or particular kind of work horse dealer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Washington, D.C.

PARENTS
NAME OF FATHER Thos. Hanson Perkins
BIRTHPLACE OF FATHER Kentucky
MAIDEN NAME OF MOTHER Katy Perkins
BIRTHPLACE OF MOTHER Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pallie Parnes
(ADDRESS) Adams St.

FILED Apr 9, 1912 W. B. Keeling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 7, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 7, 1912, to Feb 7, 1912, that I last saw him alive on Feb 7, 1912, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:
Apoplexy

Contributory Arteriosclerosis
(SECONDARY) (Duration) 7 yrs. 7 mos. 7 ds.
(Duration) Don't know mos. _____ ds.
(Signed) J. D. Bausboch M. D.
April 9, 1912 (Address) 825 Fred av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Lincoln Mem DATE OF BURIAL Feb 10, 1912
UNDERTAKER J. H. Karle ADDRESS 224 So 8th

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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