

Zeller

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

Do not use this space.

1929

1. PLACE OF DEATH

County *Crittenden*

Registration District No. *318*

File No. *27501*

Township *Springfield*

Primary Registration District No. *2001*

Registered No. *622*

City *Springfield* (No. *817 W. Thoman*) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. *817 W. Thoman* St. _____ Ward _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*
4. COLOR OR RACE *W*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Nancy A. Perry*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 13 - 1848*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
80 10 16

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Druggist*
(b) General nature of industry, business, or establishment in which employed (or employer) *Retired 1-yr*
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

10. NAME OF FATHER *Jahn Perry*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

12. MAIDEN NAME OF MOTHER *Mary Ellen Brown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

14. INFORMANT (Address) *Mrs S J Vanhook
Sunder Colo*

15. FILED *8-20-29* *Gov Sharp Registrar*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-29-1929*

17. I HEREBY CERTIFY That I attended deceased from *8-20-1929*, 19*29*, to *8-29-1929*, 19*29* that I last saw him alive on *8-27-1929*, 19*29* and that death occurred, on the date stated above, at *5:15* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

From History & physical findings Malignant Stomach Cancer of Stomach
(duration) *2* yrs. *10* mos. *10* ds.

CONTRIBUTORY (SECONDARY) *Senility*
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED *Home*
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *C. E. Zeller*, M. D.

(Address) *Springfield Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Haywood Cemetery Aug 29-29

20. UNDERTAKER *W. Klingnutco* *Springfield*

