NOV 3. 1930

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

Do not use this space.

31825

1. PLACE OF DEATH
County: Schuyler — Registration District No.: 804
Township: Salt River — Primary Registration District No.: 6044
City: ..... (No. ....., ... St. ..... Ward)

File No.: .....
Registered No.: .....

2. FULL NAME: Katherine Lamer Perrine

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John Perrine

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 10-1848

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
82	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: 0

9. BIRTHPLACE (CITY OR TOWN): .....
(STATE OR COUNTRY): Ohio

PARENTS
10. NAME OF FATHER: John Lamer
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Katherine Hoon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Ohio

14. INFORMANT: Mrs Elsie Clapper
(Address): Greenlop Mo

15. FILED: Nov 17 1930 Mrs O P Farrington
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept-16 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1930 to Sept 16 1930, 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS*:
1 Indigestion
2 IBC
3 Senile age
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED: .....
IF NOT AT PLACE OF DEATH: X
DID AN OPERATION PRECEDE DEATH? No DATE OF: .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) O P Farrington M. D.
9/16 19 30 (Address) Greenlop 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: Greenlop Mo — DATE OF BURIAL: 19

20. UNDERTAKER: L O Young — ADDRESS: Greenlop

CAUTION: PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. ... should be stated ... be properly classified.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Schuyler — Registration District No. 804 — File No. .....

Township Salt River — Primary Registration District No. 6049 — Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Katherine S. Pervine

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED Sept 18 1930. Mrs O P Parrington
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 16 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mill Egestion Causing Hypertrophied Mak & Hernia in complete failure to properly function O.P.F.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*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
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

1120

N. B.—Every item of information should be carefully supplied. AGE [illegible] 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.

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

5-31825