

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

**3411**  
Do not use this space.

REC'D FEB 23 1939

1. PLACE OF DEATH

(a) County Perry Registration District No. 660  
 (b) Township Perryville Primary Registration District No. 4396 Registered No. \_\_\_\_\_  
 (c) City Perryville (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Jane Difani  
 (a) Residence, No. 522 West St Joseph St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 12, 1859

7. AGE YEARS 79 MONTHS 7 DAYS 20 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 29, 1938, to Feb 2, 1939  
 I last saw him alive on Feb. 2, 1939. Death is said to have occurred on the date stated above, at 8:15 P.M.  
 The principal cause of death and related causes of importance were as follows:

Carcinoma of Pancreas ✓

Date of onset 6/29/38

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perry County Mo.

FATHER

13. NAME Lewis Cisell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perry County Mo.

MOTHER

15. MAIDEN NAME Louise Mattingly

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perry County Mo.

17. INFORMANT (ADDRESS) Mrs. Oscar J. Weith Perryville, Mo.

18. BURIAL PLACE Mt. Hope Cemetery DATE Feb. 5, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Perry Funeral Home Perryville Mo.

20. FILED Feb 4 1939 Geo J. Zelner Local Registrar.

Other contributory causes of importance:

Name of operation Ball-Hodges removal of tumor in duct Date of \_\_\_\_\_  
 What test confirmed diagnosis? 9/6/38 Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify: \_\_\_\_\_  
 (Signed) Bernard T. Kroul M. B.  
Perryville, Mo. (Address) 595

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

4.6

STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH SERVICES

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Albert H. Bey

Licensed Embalmer No. 3866

P. O. Address Berryville, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

3411

Do not use this space.

1. PLACE OF DEATH

(a) County Peru Registration District No. 666  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4396  
 (c) City Peruville (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) 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.  
79 7 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 2 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_ to \_\_\_\_\_ 19\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_ Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Pancreas (Primary in process)  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: 4

Name of operation Gall bladder removed & drain on liver Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) Bernard T. Koon, M. D.

(Address) Peruville Mo

SUPPLEMENTARY

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

