

REC'D JUN 13 1939

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

19679
Do not use this space.

1. PLACE OF DEATH

(a) County Ste. Genevieve 1 Registration District No. 781
(b) Township Brown Primary Registration District No. 6027 Registered No. 6
(c) City..... (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 WILLIAM AUGUST PERRY

(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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 20 1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
66 7 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER
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) COFFMAN 0
(STATE OR COUNTRY) MISSOURI 0

FATHER 13. NAME JOHN T. PERRY 1
14. BIRTHPLACE (CITY OR TOWN) COFFMAN
(STATE OR COUNTRY) MISSOURI

MOTHER 15. MAIDEN NAME BESSIE EADS

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

17. INFORMANT Mrs. Elizabeth Perry
(ADDRESS) St. Mary's Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Ozark Mo DATE May 26 1939

19. FUNERAL DIRECTOR (NAME) Rev. C. Basly
(ADDRESS) St. Genevieve Mo

20. FILED 5/26 - 1939 W. H. Thomas
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 24th 1939

22. I HEREBY CERTIFY, That I attended deceased from May 16, 1939, to May 24, 1939
I last saw him alive on May 24, 1939. Death is said to have occurred on the date stated above, at 3:58 p.m.
The principal cause of death and related causes of importance were as follows:

Streptococcus Septicemia due to
abrasion on rt leg

Date of onset
5-14-39

Other contributory causes of importance:

Chronic Hemorrhagic Nephritis
Chronic Myocarditis

undetermined

Name of operation..... Date of.....
What test confirmed diagnosis? clinical 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) Arthur E. Thomas, M. D.

(Address) St. Genevieve Mo

1914
99

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,

Geo. C. Boster

or by

Registered Apprentice No., working under my personal supervision.

Signed

Geo. C. Boster

Licensed Embalmer No. *1985*

P. O. Address *St. Lawrence St.*

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County St. Genevieve Registration District No. 781
 (b) Township Beauvais Primary Registration District No. 6027 Registered No. _____
 (c) City _____ (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 William August Perry

(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

MEDICAL CERTIFICATE OF DEATH

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

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.
	<u>66</u>	<u>7</u>	<u>4</u>	

OCCUPATION

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) _____

FATHER

13. NAME _____

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

MOTHER

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 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-24 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:

Streptococcus Septicemia due to abrasion on rt Date of onset 1939

Other contributory causes of importance: Chronic Hemorrhagic nephritis Chr myo Cardia

Name of operation _____ 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? Acc. dent. Date of injury May 7, 1939
 Where did injury occur? St. Genevieve County, Mo.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. ON OWN FARM.
 Manner of injury cut rt knee with ax
 Nature of injury Wound laceration of rt knee

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Arthur J. Sepanec M. D.
 (Address) St. Genevieve Mo.

SUPPLEMENTARY

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

Local Registrar.

