FILED MAR 1 - 1940

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

7202
Do not use this space.

1. PLACE OF DEATH
(a) County Lincoln
(b) Township Bedford
(c) City Troy
Registration District No. 491
Primary Registration District No. 4298
Registered No.
(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 Anna Perkins
(a) Residence, No. Troy Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Wilton Perkins
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May 12 - 1859
7. AGE: Years 80 Months 9 Days 3 If LESS than 1 day, hrs. or min.

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. House wife
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) Troy

FATHER
13. NAME Wright
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Emanuel Wright Moscow Mills

MOTHER
15. MAIDEN NAME Amanda Anderson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Moscow Mills

17. INFORMANT (ADDRESS) Viola Hammond

18. BURIAL, CREMATION, OR REMOVAL
PLACE City Cemetery DATE 2 - 16 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kinsler Bros

20. FILED 2 - 16 1940 Mrs Pearl Muck Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 15 1940

22. I HEREBY CERTIFY, That I attended deceased from June 1937 to 2 - 15 - 1940
I last saw alive on 2 - 15 - 1940 Death is said to have occurred on the date stated above, at 5 p.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Uremic Poison | |

Other contributory causes of importance:

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? 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) H. J. Harris, M. D.
(Address) Troy, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

50M-1-12-38 I X14628

## 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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

. S. No. 2B
M—2-21-40
I X22859

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 7202

Registration District No. 491 Primary Registration District No. 4298 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**
(a) County Lincoln
(b) City or town Troy
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Lincoln
(c) City or town Troy
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Anna Perkins
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race Black
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 80 Months 9 Days 3 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 2-16-40 (Date received local registrar) (b) Mrs Pearl Musick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 2 day 15 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature H. S. Harris (M. D. or other)
Address Troy Mo Date signed

SUPPLEMENTARY

. S. No. 2B
M—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 7202

Registration District No. 491 Primary Registration District No. 4298 Registrar's No.

SUPPLEMENTARY

**1. PLACE OF DEATH:**

(a) County Lincoln

(b) City or town Troy

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

3. (a) PRINT FULL NAME Anna Perkins

3. (b) If veteran, name war

3. (c) Social Security No. ~~[illegible]~~

4. Sex F

5. Color or race Black

6. (a) Single, widowed, married, divorced widd

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 2 day 18.

year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;

that I last saw h alive on , 19;

and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Poisoning

Due to

Due to Chronic nephritis

" myocarditis

Other conditions Arterial Hypertension

(Include pregnancy within 3 months of death) Arteriosclerosis

Major findings:

Of operations

Of autopsy

| Duration |
|---|
| |
| |
| |
| |

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature H. S. Harris (M. D. or other)

Address Troy Mo Date signed