

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Leveying Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Week
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 715 FULTON AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Grant Perkins b25
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 20
year 1940 hour _____ minute 9³⁰ a.m.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Sept. 9-1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July, 1939 to March 2nd, 1940; that I last saw him alive on March 2nd, 1940; and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

8. AGE: Years 68 Months 5 23 If less than one day _____ hr. _____ min.

Chronic Myocarditis
Due to Chronic Nephritis
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Lewis County MO
(City, town, or county) (State or foreign country)
10. Usual occupation PIPE FITTER
11. Industry or business Universal Atlas Co
MOTHER FATHER
12. Name William Perkins
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Porter
15. Birthplace MO
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy NO
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Mary Perkins
(b) Address 715 Fulton Ave. Hannibal Mo
17. (a) Burial (b) Date thereof March 4-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. Olive-Crem.
18. (a) Signature of funeral director James O'Connell
(b) Address Archibald Ave.
19. (a) 3-11-40 (b) H. C. Fisher
(Date received local registrar) (Registrar's signature)

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 B. T. Murphy (M. D. or other) _____
Address Hannibal, Mo. Date signed 3/15/40

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

Rev. 5-17-30

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.

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 Michael J. Donnell

Licensed Embalmer No. 3246

P. O. Address Hannibal, Mo

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.