

S. No. 2
-11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17876

State File No. _____

JUN 10 1940 85

Primary Registration District No. 1001

Registrar's No. 517

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution: 1025 Anguizone St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓
(Specify whether) _____
In this community 4 1/2 yrs.
years, months or days)

8. (a) PRINT FULL NAME Edith Ann Perrine 650

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Wh
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Perrine 6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased October 21 1881
(Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 14
If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Richard Sause

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

14. Maiden name Howland
15. Birthplace Indiana (City, town, or county) (State or foreign country)

18. (a) Informant A. Wright Perrine
(b) Address Chicago Ill

17. (a) Burial (b) Date thereof 7-7-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Carmel

18. (c) Signature of funeral director J. H. Murphy
(b) Address 1925 Mitchell

19. (a) May 7 1940 (b) J. J. Mitchell
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1025 Anguizone
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 2
year 1940 hour 700 minute PM

21. I hereby certify that I attended the deceased from 5-1
1940, to 5-5 1940
that I last saw her ER alive on 5-2 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertension
Myocarditis
Due to Gold's candida

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

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? _____
85
(Specify type of place) While at work? (e) Means of injury _____

23. Signature Dr. W. H. King (M. D. or other)
Address St Joseph Mo Date signed 5-6-40

ATY Dixon
Ording

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS
ST. LOUIS, MO.

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 J. L. Perry
Licensed Embalmer No. 1946
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.