

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33907**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **860A**

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

NOV 16 1940

PLACE OF DEATH:

(a) County St Louis Mo.  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1410 A N Garrison Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 2  
(Specify whether years, months or days)  
In this community Besone Yearman

8. (a) PRINT FULL NAME Bessie Peryman

3. (b) If veteran, name war No 8. (c) Social Security No. No

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

6. (b) Name of husband or wife Frank Peryman 6. (c) Age of husband or wife if alive Dead years 25 1888

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

8. AGE: Years 52 Months 2 Days 25 If less than one day hr. min.

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

10. Usual occupation maid

11. Industry or business

12. Name William Hawkins

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

14. Maiden name Louisia Brown (City, town, or county) (State or foreign country)

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

16. (a) Informant Mr. Mamie Butler (b) Address 1410 A N Garrison Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 21 40 (Month) (Day) (Year)

(c) Place: burial or cremation Green Wood Cem.

18. (a) Signature of funeral director Ellis Fun, Home (b) Address 2820 Stoddard St

19. (a) OCT 18 1940 (Date received local registrar) (b) J.F. Butler (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town St Louis Mo. (If outside city or town limits, write "RURAL")  
(d) Street No. 1410 A N Garrison Ave. (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17th, year 1940, hour 2 minute 45 M.

21. I hereby certify that I attended the deceased from 10 - 15, 1940, to 10 - 17, 1940

that I last saw him alive on 10 - 16, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration 72 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertension (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (b) Means of injury \_\_\_\_\_

23. Signature Thos. P. Baker (M. D. or other) \_\_\_\_\_  
Address 2811 1/2 Wash St Date signed 10-18

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

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by L. Boyk  
....., Registered Apprentice No. myself  
working under my personal supervision.

Signed Lomnie Boyk  
Licensed Embalmer No. 294  
P. O. Address St Louis 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.**