U. S. No. 2
I—11-10-39
Rev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 55252

Registration District No. 95

Primary Registration District No. 4179

Registrar's No. 9

36
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0

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Sullivan, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community All his life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Sullivan, Mo.
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME James Thomas Perkins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept. 15th. 1939
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
1	1	15	hr. min.

9. Birthplace Sullivan, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation none 0

11. Industry or business 0

FATHER
12. Name Thomas Perkins
13. Birthplace Sullivan, Missouri,
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ida Reeves
15. Birthplace Bourbon, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ida Perkins
(b) Address Sullivan, Mo.

17. (a) Burial (b) Date thereof II* 7- 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cave Springs, Mo.

18. (a) Signature of funeral director J. T. Williams
(b) Address Sullivan, Missouri,

19. (a) 11-7-40 (b) O. A. Factor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5th.
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug Aug 28, 1940, to ~~Nov~~ Sept 26, 1940;
that I last saw him alive on Sept 26, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic diarrhea	3 months
Due to Malnutrition	2 months
Due to	
Other conditions (Include pregnancy within 3 months of death)	

11413

Major findings:
Of operations None
Of autopsy None

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? 933
(Specify type of place)
While at work? _____ (e) Means of injury _____ 3

23. Signature Dr. L. R. Garnes D. O.
(M. D. or other)
Address Sullivan Mo Date signed Nov 7 1940

(Licensed Embalmer's Statement on Reverse Side)

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. T. Williams

Licensed Embalmer No. 427

P. O. Address Sullivan, 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.