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28390

JUL 9 1941

765

6266

Primary Registration District No. _____ Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Osceola (Rural)
(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 _____
In this community 2 Months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Clair
(c) City or town Osceola (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charlotte Perkins

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

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James J. Perkins 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased Mar. 4 1851
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 2 10 hr. min.

9. Birthplace St. Clair Co. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
MOTHER FATHER { 12. Name Mathew Francis
13. Birthplace Virginia
14. Maiden name Polly Allen (State or foreign country) Virginia
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant J. J. Perkins
(b) Address Osceola MO.

17. (a) Burial (b) Date thereof May 15 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Allen Cem. Collins Mo.

18. (a) Signature of funeral director Joseph & Firestone
(b) Address Collins Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14
year 1941 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 5-8-41
to 5-11-41
that I last saw him alive on 5-11-41
and that death occurred on the date and hour stated above.

Immediate cause of death
arrhythmia fibrillation
cardiac decompensation
Due to age 90
Duration 3-4 days
probably
myocardium

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 T. H. J. Angles, Jr. (M. D. or other) M. D.
Address Osceola, Mo. Date signed 6-30-41

RECEIVED
District Health Officer No. 7,
District File Number 7-41-1118
Date Filed 7-7-41

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.....

C. S. Hathaway
working under my personal supervision.

Registered Apprentice No. *269*

Signed *Paul Justine*

Licensed Embalmer No. *3990*

P. O. Address *Collins rd*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 765

Primary Registration District No. 6266

Registrar's No. 2

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town _____
(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 _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Charlotte Perlins
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
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 Months Days 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) _____ (b) Date thereof (Month) (Day) (Year) _____
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) 7-1-1941 (b) Ruth Seers
(Date received local registrar) (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 May day 14
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

5-22557

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.