

No. 2
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS
FILED AUG 29 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

St. Clair
27633
State File No.
Registrar's No. **232**

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stickler Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 61 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lizzie Belle Perry

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Charles Perry 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 27 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 8 20 hr. _____ min.

9. Birthplace Macon Co., Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Vance Brown

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Sarah Johnson

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

16. (a) Informant Plin Perry

(b) Address Kirksville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation Novinger, Mo.

18. (a) Signature of funeral director Dee Riley

(b) Address Kirksville, Mo.

19. (a) Craig W. W. (Date received from registrar) (b) Spencer L. Freeman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirksville (If outside city or town limits, write "RURAL")
(d) Street No. 901 S. Wabash. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 17 year 1940 hour 4:00 minute _____ P.M.

21. I hereby certify that I attended the deceased from Nov 13 1940, to Nov. 17 1940 that I last saw her alive on Nov. 17 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation

Due to chronic myocarditis

Due to _____

Other conditions Chr. Glomerulo-Nephritis
(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) (e) Means of injury _____

23. Signature Dr. Sticler (M. D. or other) JMD

Address Kirksville Mo Date signed _____

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 8-41-1565

Date Filed AUG 21 1941

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. E. Riley

Licensed Embalmer No. 3907

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.