

FILED NOV 19 1942

Registration District No. **749**

Primary Registration District No. **1002**

Registrar's No. **4229**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K.C. Conv. Home #3200 noledge
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5-27-42-11-12-42**
(Specify whether years, months or days)
 In this community **78 Yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
 (c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2525 Cypress**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **William Perry**

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

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 **March 4 1845**
(Month) (Day) (Year)

8. AGE: Years **97** Months **8** Days **8**
 If less than one day **hr. min.**

9. Birthplace **MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer Ret. 40 yrs**

11. Industry or business

MOTHER FATHER { 12. Name **Phillip Perry**
 { 13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)
 { 14. Maiden name **Eliza Emily Howard**
 { 15. Birthplace **K.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs P.H. Jackson**
 (b) Address **5818 Woodland**

17. (a) **Removal** (b) Date thereof **Oct 14 42**
(Burial, cremation, or removal) (Month) (Day) (Yr)
 (c) Place: burial or cremation **Wadsworth Kans**

18. (a) Signature of funeral director **Starkman**
 (b) Address **7406 Wornell**

19. (a) **11-13-42** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **12**
 year **1942** hour **10** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **1937** to **Nov 12 1942**
 that I last saw him alive on **Nov 6 1942**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Uremic Coma -** Duration

Due to **Senility - 132:2**

Due to **L**

Other conditions **None Significant**
(Include pregnancy within 3 months of death)

Major findings: **None**
 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) **L**
 (b) Date of occurrence **L**
 (c) Where did injury occur? **L**
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature **Roeth Perry D** (M. D. or other) **MD**
 Address **4800 E 24** Date signed **11-13-42**

WHILE FILLING IN - USE UNFADING BLACK INK - MAKE A FURNITURE RECORD

1961
JAN 15
1961

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.....

Harvey Roe
Licensed Embalmer No. *2810*

P. O. Address: *17-6-2nd*

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

State File No. 36365-
Registrar's No. 4229

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Ransom city
(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 _____ (Specify whether)
years, months or days)

3. (a) PRINT FULL NAME William Perry
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W
6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased ma 4 1940
(Month) (Day) (Year)

8. AGE: Years 97 Months 8 Days mo If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) 11-13-42 M. D. Cronin
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 Day 13 Year 1942 Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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

SUPPLEMENTARY

S-36325 1942