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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

LED JUN 7 1943

Registration District No. 517

Primary Registration District No. 6076

Registrar's No. 1299

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
503 St. Joseph St.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Florissant
(If outside city or town limits, write "RURAL")

(d) Street No. 503 St. Joseph St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rafeul W. Perkins

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Minerva E. Perkins

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Nov. 22 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>6</u>	<u>9</u>	_____ hr. _____ min.

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

10. Usual occupation Labor

11. Industry or business _____

12. Name Charles Perkins

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

14. Maiden name Leah Clark

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

16. (a) Informant Mrs. Minerva E. Perkins

(b) Address Florissant, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4/43
(Month) (Day) (Year)

(c) Place: burial or cremation Fee Fee Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) JUN 3 1943 (Date received local registrar)

(b) C. S. McLeary, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1943 hour 6.00 minute P.M.

21. I hereby certify that I attended the deceased from 5/28, 1943, to 5/31, 1943
that I last saw him alive on 5/30, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis-Pneumonia Duration 4 days

Due to Senility-cold

Due to _____

Other conditions arteriosclerosis-Dementia
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 107

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 C. S. McLeary (M. D. or other M.D.)
Address _____ Date signed _____

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

16
10
0

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

Dr. C.O. Hughes
Ferguson, Mo.

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 *Neville M. Brammer*
Licensed Embalmer No. *4200*
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, fact should be so stated above.