

Registration District No. **12**

Primary Registration District No. **5070**

Registrar's No. **13**

1. PLACE OF DEATH:

(a) County **Barton**
 (b) City or town **Miffland, Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Miffland 1300. Miffland 1300
 (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 **Barton**
 (c) City or town **Miffland, Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **William Robert Perkins**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **500-01-2702**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Cora Belle Perkins** 6. (c) Age of husband or wife if alive **62** years
 7. Birth date of deceased **July 14 1876**
 (Month) (Day) (Year)

8. AGE: Years **67** Months **7** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace **Thayer County, Kansas**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business _____

MOTHER, FATHER
 { 12. Name **John P. Perkins**
 { 13. Birthplace _____
 { 14. Maiden name **Luiza Seal**
 { 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. W. R. Perkins**

(b) Address **Miffland, Mo.**

17. (a) **Burial** (b) Date thereof **2-24-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lake Cemetery**

18. (a) Signature of funeral director **J. D. Beemy + Sons**

(b) Address **Shepherd, Mo.**

19. (a) **2-24-44** (b) **Martha Kever**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **22** year **1944** hour **10** minute **30** M.

21. I hereby certify that I attended the deceased from **20** 19**44** to **2-22** 19**44**

that I last saw him alive on **2-22** and that death occurred on the date and hour stated above.

Immediate cause of death **peritonitis**

Due to **Gastric Ulcer + rupture of ulcer**

Due to **Ulcer**

Other conditions _____

(Include pregnancy within 3 months of death) **Mal**

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) _____

23. Signature **J. B. Amster** (M. D. or other) _____

Address **Jerico Spring** Date signed **2-28-44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

