

No. 2  
5-43  
-17-39  
X38671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34881

State File No. \_\_\_\_\_

FILED OCT 19 1944  
Registration District No. 23

Primary Registration District No. 5825

Registrar's No. 4356

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Parma Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home Como Surry  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
(Specify whether \_\_\_\_\_)  
In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid  
(c) City or town Parma "Rural" 72  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Carolyn Sue Perkins  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 16 - 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 8 16 hr. \_\_\_\_\_ min.

9. Birthplace Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation Baby

11. Industry or business \_\_\_\_\_  
12. Name Lowell Perkins  
13. Birthplace Mo. (City, town, or county) (State or foreign country) 0  
14. Maiden name Eva Medlin  
15. Birthplace Mo. (City, town, or county) (State or foreign country) 0

MOTHER FATHER

16. (a) Informant Lowell Perkins  
(b) Address Parma Rural  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-5-44  
(Month) (Day) (Year)  
(c) Place: burial or cremation Bernie

18. (a) Signature of funeral director Lander F.H.  
(b) Address Campbell Mo.

19. (a) Oct. 4/44 (Date received local registrar) (b) Mrs. S.B. Rademaker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2  
year 1944 hour 11 minute 55 P.M.  
21. I hereby certify that I attended the deceased from Jan 14, 1944 to 9, 1944  
that I last saw her alive on 9-2, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Convulsions  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 86.

Duration Life  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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) (c) Means of injury 2  
23. Signature F O Kelley (M.D. or other) DD  
Address Bernie Mo. Date signed 9-7-44

1028 1. (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2,

District File Number 1044-131

Date Filed 10-11-44

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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 *E. W. Sanders*

Licensed Embalmer No. 2289

P. O. Address *Campbell*

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.