No. 2
9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 3 1945

Registration District No. 383

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3-0-3-75635

State File No. 10074

Registrar's No. 21

1. PLACE OF DEATH:
(a) County: Lawrence Co
(b) City or town: Mt Vernon Mo Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Home (Specify whether
In this community: 50 yr
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Lawrence
(c) City or town: Mt Vernon Rural 53
(If outside city or town limits, write "RURAL")
(d) Street No.: 1 mile East of town 0
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: ROSE ANN PERRIMAN
3. (b) If veteran, name war: no
3. (c) Social Security No.:
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: E. H. Perriman
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
77	5	10	hr. min.

9. Birthplace: Ky (City, town, or county) (State or foreign country)
10. Usual occupation: House Keeper
11. Industry or business:
MOTHER FATHER
12. Name: James White
13. Birthplace: Ill (City, town, or county) (State or foreign country)
14. Maiden name: Sarah Allen
15. Birthplace: Ky (City, town, or county) (State or foreign country)
16. (a) Informant: Mr Perriman
(b) Address: Mt Vernon Mo
17. (a) Summit Cem (Burial, cremation, or removal) (b) Date thereof: Mar 17 1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Summitt
18. (a) Signature of funeral director: H. B. Fossett
(b) Address: Mt Vernon Mo
19. (a) 3-20-45 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Mar day: 16
year: 1945 hour: 9 PM minute: M.
21. I hereby certify that I attended the deceased from Mar. 12, 1945 to Mar. 16, 1945
that I last saw h. alive on Mar. 16, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: apoplexy gzb	4 days
Due to:	
Due to: Hypertension	unknown
Other conditions (Includes pregnancy within 3 months of death): P. A. Holmes	
Major findings: Of operations: none	
Of autopsy: no	

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: P. A. Holmes (M. D. or other)
Address: Mt Vernon Mo Date signed: 3-19-45

1337

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 445-382
Date Filed APR 2 1945

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 May L. Fossett

Licensed Embalmer No. 4252

P. O. Address Mt Vernon, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 31

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Rural Mt Vernon Twp
(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
years, months or days)

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

3. (a) PRINT FULL NAME Rose Ann Perriman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 6 (Month) 1868 (Day) (Year)

8. AGE: Years 77 Months 5 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 3-20-45 (Date received local registrar) (b) Andy Crawford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 26
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

10074