

FILED JUN 11 1945
Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 1283

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since Oct. 11, 1944
(Specify whether)

In this community asa bove
years, months or days

3. (a) PRINT FULL NAME Robert PERKINS

3. (b) If veteran, name war World I

3. (c) Social Security No. 361-09-1428

4. Sex Male 2

5. Color or race Negro

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

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

7. Birth date of deceased November 9 1890
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>6</u>	<u>23</u>	hr. <u>-</u> min. <u>-</u>

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

10. Usual occupation Laborer

11. Industry or business -

12. Name Jesse Perkins

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

14. Maiden name Anna Washington

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

16. (a) Informant Clinical Clerk, Vet. Adm. Facility,
(b) Address Jefferson Barracks, Mo.

17. (a) Removal (b) Date thereof 6/15/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cairo, Ill

18. (a) Signature of funeral director H. E. J. ...
(b) Address 3615 - Edison Ave

19. (a) JUN 4 1945 (b) E. B. M. Carson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Alexander

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

(d) Street No. 312 24th Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1945 hour 5:45 minute - P. - M. -

21. I hereby certify that I attended the deceased from October 11 1945 to June 2 1945
that I last saw him im alive on June 2 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the Rectum
Duration Unknown

Due to - - - 46 d

Due to - - -

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

Major findings:
Of operations Colostomy, Nov. 13, 1945

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) NO

(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 E. V. EDWARDS Major, M. C. (M. D. or other)
Clinical Director.
Address Jefferson Brks., Mo. Date signed 6/4/45

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

JUN 1 1945

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999
11

2

Duration
Unknown

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

STATE OF NEW YORK

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.....

My self

Registered Apprentice No.....

working under my personal supervision.

Signed.....

M. J. Hewitt

Licensed Embalmer No. *2266*

P. O. Address *2812 Thomas St.*

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.