

FILED AUG 4 1945

Registration District No.

Primary Registration District No. 5551

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

**1. PLACE OF DEATH:**

(a) County Newell

(b) City or town West Plains Mo. R.F.D.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lanell Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 78 y 10 - years, months or days

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**3. (a) PRINT FULL NAME** Martha Francis Perkins

3. (b) If veteran,  name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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4. Sex 71 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Jack Perkins 6. (c) Age of husband or wife if alive 1867 years

7. Birth date of deceased: 3/26 - (Month) (Day) (Year)

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8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>3</u>	<u>26</u>	hr. min.

9. Birthplace Newell Co. Mo. D  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm Buck

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

14. Maiden name Olivia Anderson

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

16. (a) Informant Mrs. G. N. Cull

(b) Address West Plains, Mo.

17. (a) B (b) Date thereof 7-10-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director: [Signature]

(b) Address West Plains, Mo.

19. (a) 7-15-45 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Newell

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

(d) Street No. R.F.D.

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 7 day 30 year 45 hour 6 minut 30 A. M.

21. I hereby certify that I attended the deceased from Nov. 1941, to Dec 1944  
that I last saw her alive on Dec. 14 - 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis Long  
Duration Long

Due to Chronic myocarditis Long  
Result Peritd

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations [Signature]

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. P. Krumholz (Name or other) P  
Address West Plains, Mo. Date signed 7-12-45  
Krumholz

1125

RECEIVED

District Health Officer No. 5,

District File Number 845319

Date Filed 8-13-45

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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 Raymond D. Roberts

Licensed Embalmer No. 3435

P. O. Address Marble Hill, 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.

Registration District No. 141 Primary Registration District No. 5551

1. PLACE OF DEATH:

(a) County Haskell  
(b) City or town Rural - Haskell  
(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) \_\_\_\_\_ (Specify whether

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 Martha F. Perkins

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 w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased mar 26 (Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1995 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature H. Kromholz (M. D. or other) \_\_\_\_\_

Address West Plains, Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

24117