

FILED JAN 8 1946
Registration District No. **248**

Primary Registration District No. **4369**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Newton**
(b) City or town **Seneca**
(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 **Newton** **73**
(c) City or town _____ **4**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Shirley Ann Perry

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

4. Sex **female** / 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec. 7th 1945**
(Month) (Day) (Year)

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

9. Birthplace **Joplin Missouri** **11**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name **Paul Jay Perry** **0**
13. Birthplace **Webb City Missouri** (City, town, or county) (State or foreign country)
14. Maiden name **Ruby Griner**
15. Birthplace **Seneca Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **X Ruby Perry**
(b) Address **2613 main Joplin**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec. 24 1945** (Month) (Day) (Year)

(c) Place: burial or cremation **Seneca Mo**
18. (a) Signature of funeral director **Bob Chase** (b) Address **Seneca Mo**
19. (a) **Jan. 2 - 1946** (Date received local registrar) (b) **Nettie Norris** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec. 23** day year **1945** hour **7 30** minute **A** M.

21. I hereby certify that I attended the deceased from **Dec. 12**, 19**45**, to **Dec. 23**, 19**45** that I last saw her alive on **Dec. 23**, 19**45** and that death occurred on the date and hour stated above.

Duration
Immediate cause of death
Congenital malformation of heart
Premature Birth

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy **159**

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) (c) Mode of injury _____
23. Signature **John B. Roberts** (M. D. or other) **D.O.**
Address **Seneca Mo** Date signed **12-24-45**

WRITE PLAINLY—USE UNFADING INK

RECEIVED

District Health Officer No.

District File Number 12-45-236

Date Filed January 3-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 248

Primary Registration District No. 4369

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Seneca
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Shirley A Perry

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 S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Dec 7, 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ 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 _____

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 _____
(Burial, cremation, or removal) (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Seneca
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____;

that I last saw him _____ 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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A FINGERPRINT COPY

80

41972