

S. No. 2
DOM-5-43
ev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Lemmon Sr.
State File No. 19998
Registrar's No. 485

Registration District No. 128

Primary Registration District No. 2000

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
15072

1. PLACE OF DEATH:

(a) County Greene
Springfield

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

(c) Name of hospital or institution 1125 Nichols
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 Years
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 1125 Nichols
(If rural, give location)

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

3. (a) PRINT FULL NAME Ida May Perryman

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8
year 1946 hour 10:00 minute _____ p. _____ M.

21. I hereby certify that I attended the deceased from 1942
_____, 19____, to 6/8/46, 19____;
that I last saw h. er alive on about a year ago, 19____;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Marion A. Perryman

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

7. Birth date of deceased Feb. 1, 1881
(Month) (Day) (Year)

Immediate cause of death Angina pectoris

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>65</u>	<u>4</u>	<u>7</u>	_____ hr. _____ min.

9. Birthplace Near Conway Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name unk.

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

14. Maiden name unk.

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Anna Wilkerson

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 6/12/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn

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? _____

18. (a) Signature of funeral director A.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 6-10-46 (b) 5 W Hardy
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Dr. Lemmon Sr. (M. D. or other) M.D.

Address Springfield, Mo. Date signed 6/10/46

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.....

..... **Roy H. Mercer Jr.**, Registered Apprentice No. **380**,
working under my personal supervision.

Signed *Walter E Hamilton*

Licensed Embalmer No. **3808**

P. O. Address **Springfield, 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.

1