

FILED AUG 1 1946

Registration District No. 28

Primary Registration District No. 4345

Registrar's No. 157

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution No.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No.
In this community 12 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME

J. W. PERKINS

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

4. Sex M. Color or race W.

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife SARAH PERKINS

6. (c) Age of husband or wife if alive 2 years

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

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

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

10. Usual occupation NONE.

11. Industry or business

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)

16. (a) Informant D. D. Hoots

(b) Address CAMPBELL

17. (a) BURIAL (b) Date thereof July 31-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mausoleum

18. (a) Signature of funeral director Randal L. Mitchell

(b) Address Hector Ark

19. (a) 7-31-46 (b) Allen L. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid
(c) City or town New Madrid
(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 July day 30
year 1946 hour 3 minute 30 M.

21. I hereby certify that I attended the deceased from July 1st, 1946, to July 31, 1946
that I last saw him alive on July 29 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial (Chronic)
Due to Hypertension - Senility

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

Major findings: Of operations and
Of autopsy _____

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 0
Signature O. B. Chandler (M. D. or other) 0
Address New Madrid Mo Date signed 7/31/46

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

72
4
0

26884

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 846-988

Date Filed 8-14-46

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.....

....., 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.