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20605

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED JUL 11 1947

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 589

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
545 Poplar St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 2 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 545 Poplar
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Franklin Perkins.

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Anna Perkins 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Feb. 9th. 1864
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 22 If less than one day
hr. _____ min. _____

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

10. Usual occupation retired farmer

11. Industry or business _____

12. Name James Perkins

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

14. Maiden name Margaret Keltner

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

16. (a) Informant Mrs. A.M. Ringenberg

(b) Address 545 Poplar, Springfield, Mo.

17. (a) burial (b) Date thereof July, 3, 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McConnell cem.

18. (a) Signature of funeral director T.W. Maples
Clever, Mo.

(b) Address _____

19. (a) 7-7-47 (b) T.E. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1st.
year 1947 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from June 28 - 47
to July 1 - 47
that I last saw him alive on July 1
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 10 Days

Due to _____

Due to _____

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

Major findings: Of operations § 3 A

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) _____ (Specify type of means of injury) CMD

23. Signature Max P. [unclear] (M. D. or other) MD

Address Springfield Mo. Date signed 7-4-47

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

MOTHER FATHER

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..... *J.W. Maples*

Licensed Embalmer No..... 2985

P. O. Address..... *Clover, 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.