

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3120

State File No. ....

FILED JAN 19 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **191**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>University City 96</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>N.R. - 6563 Avalon 35</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Carlton</b>	b. (Middle) <b>Joel</b>	c. (Last) <b>Perrin</b>	4. DATE OF DEATH (Month) (Day) (Year)	<b>1 6 1949</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 29, 1908</b>	9. AGE (In years last birthday) <b>40</b>	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Wagner Electric</b>	11. BIRTHPLACE (State or foreign country) <b>Foster, Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Cameron Perrin</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Hufstedler</b>	14. NAME OF HUSBAND OR WIFE <b>Lucille Perrin</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lucille Perrin - 6563 Avalon</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <b>Ruptured Aneurysm Left Middle Cerebral Artery</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>None</b> DUE TO (c) <b>None</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 5, 1949** to **Jan 6, 1949** that I last saw the deceased alive on **Jan 6, 1949**, and that death occurred at **9:30 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Ray Compton</b>	23b. ADDRESS <b>601 27 Page Bldg.</b>	23c. DATE SIGNED <b>1-7-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-8-49</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Paragould, Ark.</b>
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DATE REC'D BY LOCAL REG. <b>JAN 7 1949</b>	REGISTRAR'S SIGNATURE <b>J. Blacato</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe - St. Louis, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

**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.....

Student Embalmer No. ....

working under my personal supervision.

Signed

*Gustav W Dietrich*

Signed.....

Student Embalmer

Licensed Embalmer No. ....

*4329*

P. O. Address

*St. Louis 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.