

No. 300
10. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15478

State File No.

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 201

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) N.E. of Kirksville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Isaac c. (Last) Perkins			4. DATE OF DEATH (Month) (Day) (Year) May 28.52		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 8, 11, 1871	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 8 Days 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Gascon ade Co, Mo	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME William J. Perkins		13b. MOTHER'S MAIDEN NAME Eliza N. Williams		14. NAME OF HUSBAND OR WIFE Anna Schwedes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, if unknown) Unk (If in war or dates of service) Unk		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. W.R. Fortney Kirksville, Mo	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Oct 1, 1948, to May 28, 1952; that I last saw the deceased alive on May 27, 1952, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mrs. E. L. ...	23b. ADDRESS 1. Culcauer, Mo.	23c. DATE SIGNED May 29, 1952
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE May 30, 1952	24c. NAME OF CEMETERY OR CREMATORY East Center Cemetery
		24d. LOCATION (City, town, or county) (State) N.E. Kirksville, Mo

DATE REC'D BY LOCAL REG. 6-3-52	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Randolph Davis - Kirksville, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

513

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.

Student
Student Embalmer

Signed Donald L. Roberts

Licensed Embalmer No. 4722

P. O. Address Perksville, 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.