

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6202**  
**687**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>50 yrs</u>		d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Northeast Reformer</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Northeast Reformer</u>		e. STREET ADDRESS (If rural, give location) <u>6621 E 10 3208</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ellen</u> b. (Middle) _____ c. (Last) <u>Perry</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1-30-53</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Div. 3</u>	8. DATE OF BIRTH <u>9-9-1981</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Sedalia Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Edmund Maroney</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Foley</u>		14. NAME OF HUSBAND OR WIFE <u>James L. Perry</u>	
--	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>487-03-0915</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Catherine Perry</u>		ADDRESS <u>6221 E 10</u>
---	---	---	--	--------------------------

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) <u>Cerebral Haemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH  <u>33 1/2 H</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gen. Art. Sclerosis</u> DUE TO (c) <u>Fracture Rt Hip</u>		
	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) _____	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) _____	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 Jan, 1952 to Jan 30, 1953, that I last saw the deceased alive on Jan 28, 1953, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul A. G. Johnson MD</u> (Degree or title)	23b. ADDRESS <u>MD 3011A Ludley Ave</u>	23c. DATE SIGNED <u>1/31/53</u>
---	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-2-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
---	-------------------------	---	--

DATE REC'D BY LOCAL REG. <u>2-2-53</u>	REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Skiel</u>	ADDRESS <u>H.C. Mo.</u>
--	---	---	-------------------------

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

open 11111111

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 .....  
Signature of Student Embalmer

Signed *John P. Shick* .....

Licensed Embalmer No. *362*

P. O. Address *K 6 Md* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.