

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 20 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4567

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>27 YEARS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOSEPH HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>5323 ELLCID AVENUE</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>RUSSELL</u>	b. (Middle) <u>R.</u>	c. (Last) <u>PEARY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 26 1954</u>
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5. SEX <u>D</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-26-1889</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETURNED AMOS. POSTAL CLERK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RAILWAY SERVICE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>SABETHA KANS.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ELIAS PERRY</u>	13b. MOTHER'S MAIDEN NAME <u>RUTH THOMPSON</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. MINNIE PERRY</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. MINNIE PERRY</u>	ADDRESS <u>5323 ELLCID AVE KANSAS CITY MO</u>
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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, asthemia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
	ANTECEDENT CAUSES <u>C Anorexia</u>		
	DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS <u>Paralytic ileus</u>		<u>4 days</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Massive carcinoma stomach - Metastases</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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.) <u>lower peritoneal cavity</u>	21c. CITY, TOWN, OR TOWNSHIP (County, State) (Specify)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept. 26 1954</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Sept.</u>
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22. I hereby certify that I attended the deceased from Dec 13 1954 to Sept 26 1954 that I last saw the deceased alive on Dec 26, 1954 and that death occurred at 5:17 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. G. Willits M.D.</u>	(Degree or title) <u>D</u>	23b. ADDRESS <u>1103 Grand Ave</u>	23c. DATE SIGNED <u>9/28/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>SEPT, 29 54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	24d. LOCATION (City, town, or county) (State) <u>ST JOSEPH MO</u>
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DATE REC'D BY LOCAL REG. <u>9-29-54</u>	REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D. Newcomer</u>	ADDRESS <u>1337 BRUSH CREEK KANSAS CITY, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Wm. G. Willits

Nov 1919

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 B Lewis*

Licensed Embalmer No. 487

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.