

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26449**

FILED AUG 1 - 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6370**

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

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY **St. Louis**

b. CITY (If outside corporate limits, write RURAL and give OR TOWN **Reston, Missouri**) c. LENGTH OF STAY (in this place) _____

c. CITY OR TOWN **University City** d. Is residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **Bernard Nursing Home 37**
4385 Maryland Ave.

e. STREET ADDRESS (If rural, give location) **27 370 Alta Dena Ct.**

3. NAME OF DECEASED
a. (First) **LENA** b. (Middle) **FLORENCE** c. (Last) **PERRY**

4. DATE OF DEATH **July 8 1957**

5. SEX **female** 6. COLOR OR RACE **white**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed**

8. DATE OF BIRTH **Aug. 15, 1880**

9. AGE (In years last birthday) **76** IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Mins. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **at home**

10b. KIND OF BUSINESS OR INDUSTRY **none**

11. BIRTHPLACE (City and State or Foreign Country) **Providence Road Island**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Frank T Mauchester**

13b. MOTHER'S MAIDEN NAME **Hannah Gardner**

14. NAME OF HUSBAND OR WIFE **William Clark Perry**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** (If yes, give war or dates of service) _____

16. SOCIAL SECURITY NO. **none**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Mrs. Carpenter 370 Alta Dena Ct.**

18. CAUSE OF DEATH MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Cardiac decompensation**

INTERVAL BETWEEN ONSET AND DEATH **3 months**

ANTECEDENT CAUSES DUE TO (b) **Arteriosclerosis**

15 yrs.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS DUE TO (c) **Nephrosclerosis**

15 yrs.

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? **2**
YES NO

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) **442X**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from **7-20-43**, 19____, to **7-8-**, 19**57**, that I last saw the deceased alive on **July 8, 1957**, that death occurred at **4:25p m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **David M. Skilling M.D.**

23b. ADDRESS **18 South Kingshighway**

23c. DATE SIGNED **7-9-57**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**

24b. DATE **July 10, 1957**

24c. NAME OF CEMETERY OR CREMATORY **Boston City Cemetery, Boston, Mass.**

24d. LOCATION (City, town, or county) (State) **Boston, Mass.**

DATE REC'D BY LOCAL REG. **JUL 9 57**

REGISTRAR'S SIGNATURE **Carl Smith No 283.**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **C.R. Lupton and Sons 7233 Delmar Blv.**

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 *Clarence H. Murray*

Licensed Embalmer No. *4011*

P. O. Address *St. Louis*

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.