

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38870

STATE FILE NUMBER

FILED NOV 12 1957

Registration District No. 337 Primary Registration District No. 4496 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <u>SHELBY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHELBYVILLE, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SHELBYVILLE, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u> Length of stay in 1b <u>6 YRS</u>		d. STREET ADDRESS (If outside, give location) <u>SHELBYVILLE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>JO</u> Last <u>PERRY</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>4</u> Year <u>1957</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 9, 1873</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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 _____	11. BIRTHPLACE (City and state or country) <u>SHELBY COUNTY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13. FATHER'S NAME <u>JOSEPH M. PERRY</u>	14. MOTHER'S MAIDEN NAME <u>ELIZABETH JEFFRIES</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>MRS VIVIAN SAKING SHELBYVILLE MO</u> Address _____
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis, Cerebral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20g. I attended the deceased from <u>Oct 10-1957</u> to <u>Nov 4, 1957</u> and last saw her <u>Nov 4-1957</u> alive on <u>Nov 4-1957</u>
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Death occurred at <u>about 12:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE (Degree or title) <u>P. C. Alexander M.D.</u>	22b. ADDRESS <u>Shelbyville Mo</u>	22c. DATE SIGNED <u>11-5-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov 6, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CHARENCE, MISSOURI</u>
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24. FUNERAL DIRECTOR ADDRESS <u>GREENING - CHARENCE, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 7 1957</u>	26. REGISTRAR'S SIGNATURE <u>Uda Garrison</u>
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service
300 1-56
All symptoms will be listed. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

19-0

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 *Charles V. Green*

Licensed Embalmer No. *46*

P. O. Address *Claremont*

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.