

1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Diehlstadt		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Diehlstadt		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home			Length of stay in 1b		d. STREET ADDRESS Diehlstadt		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle P. Last Perkins				4. DATE OF DEATH Month Nov Day 29 Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 19, 1867		9. AGE (In years last birthday) 90	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Union Co., Ky.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Perkins				14. MOTHER'S MAIDEN NAME Leah Clark				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Laura Perkins Diehlstadt, Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arterio-sclerosis DUE TO (b) A. S. Heart disease DUE TO (c) Renal Arterio-sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) Senility							INTERVAL BETWEEN ONSET AND DEATH gradual onset 2 yrs +	
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.)					
20c. TIME OF INJURY Hour _____ Month, Day, Year 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		
21. I attended the deceased from past 10 yrs and last saw ^{him} alive on 11/28/57 Death occurred at 12:40 P. M. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE E. Charles Fleming M.D. (Degree or title)				22b. ADDRESS Charleston Mo.		22c. DATE SIGNED 12/14/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/2/57	23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) Charleston, Mo.			
24. FUNERAL DIRECTOR Mc Mickle, Charleston, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 12-26-57	26. REGISTRAR'S SIGNATURE Mrs. Ella Hunter	

DATE RECEIVED DEC 30 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1257-273

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 *E. J. [Signature]*

Licensed Embalmer No. 4694

P. O. Address Charleston

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.