

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029467

FILED VS SEP 4 1959

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 189

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Misouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie		c. CITY OR TOWN Kansas City	
Length of stay in 1b 7 1/2 Years		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hosp.		d. STREET ADDRESS (If outside, give location) 105 East 5th St.	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) Toney Perry			4. DATE OF DEATH August 24 1959		
First	Middle	Last	Month	Day	Year

5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/4/1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Min.
--------------------	-------------------------------	---	----------------------------------	----------------------------------	---	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Italy	12. CITIZEN OF WHAT COUNTRY USA
---	-----------------------------------	--	---

13a. FATHER'S NAME John Perry	13b. MOTHER'S MAIDEN NAME unk	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

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. none	17. INFORMANT Frank Perry	Address 3405 Flora
---	--	-------------------------------------	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 yrs. 4 yrs.
IMMEDIATE CAUSE (a) Cerebral Vascular Accident		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Haemophilia DUE TO (c) Arterio Sclerosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
---	---	--

20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
---	------------------

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 **4-30-1955** to **8-24-1959** and last saw ^{her}/_{him} alive on **8-24-1959**
Death occurred at **12:15 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

21. SIGNATURE (Degree or title) W. O. Guernsey, M.D.	22. ADDRESS 314 Hwy Bldg	22. DATE SIGNED 8/24/59
--	------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial	23b. DATE 8-27-1959	23c. NAME OF CEMETERY OR CREMATORY St. Gabriel Cem.	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
--	-------------------------------	---	--

24. FUNERAL DIRECTOR Assorted Bur	ADDRESS Ke Mo	25. DATE RECD. BY LOCAL REG. 8-25-1959	26. REGISTRAR'S SIGNATURE N. B. Longford
---	-------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leonard Passantino

Licensed Embalmer No. 4554

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.