

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 18 1960

042

Primary Registration District No. 1000

Registrar's No. 41

=60-000374  
STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>			Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rt #2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Brenda</b> Middle <b>Sue</b> Last <b>Perks</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>7,</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1960</b>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HR Hours <b>1</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>St. Joseph Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>James Clifford Perks</b>			13b. MOTHER'S MAIDEN NAME <b>Alice Lavern Honeycutt</b>			14. NAME OF HUSBAND OR WIFE <b>none</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Alice Perks, Rt #2 St. Joseph, Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis, extensive, congenital</b>						INTERVAL BETWEEN ONSET AND DEATH <b>27 hrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Prematurity</b>								
DUE TO (c) <b>Promoteur rupture of membranes</b>								
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 type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <b>1</b> Month, Day, Year <b>1-7-60</b>		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.) <b>Birth</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>St. Joseph, Mo</b>		
21. I attended the deceased from <b>Birth</b> to <b>1-7-60</b> and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>H.C. Williamson M.D.</b>				22b. ADDRESS <b>St. Joseph, Mo</b>		22c. DATE SIGNED <b>1/11/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/9/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (city, town, or county) (State) <b>St. Joseph, Mo</b>		
24. FUNERAL DIRECTOR <b>John Crupp</b>			ADDRESS <b>St. Joseph, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Jan 14, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Ms. Clark Goodell</b>	

DOCUMENT

BY AFFIDAVIT OF H.C. Williamson M.D. CERTIFICATION

**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. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John E. Rupp

Licensed Embalmer No. 798

P. O. Address St. Joseph

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.