

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

-60-004363

INDEXED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 38

STATE FILE NUMBER

| | | | | | |
|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> | | Length of stay in 1b <u>3 1/2 hrs.</u> | c. CITY OR TOWN <u>Ferguson</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>St. Louis Co. Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>411 St. Louis Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ADELINE</u> Middle <u>PERRY</u> Last <u>PERRY</u> | | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1960</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>1-24-81</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 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 <u>---</u> | 11. BIRTHPLACE (City and state or country) <u>Smith Center, Kans. U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> |
| 13a. FATHER'S NAME <u>Frank Fuller</u> | | 13b. MOTHER'S MAIDEN NAME <u>Emma Ifland</u> | | 14. NAME OF HUSBAND OR WIFE <u>Charles E. Perry</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>493-07-8104D</u> | 17. INFORMANT Address <u>Beatrice Marsh, Ferguson, Mo.</u> | | |
| 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 <u>2 days</u> |
| IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Perforated Gastric Ulcer</u> | | | | | |
| DUE TO (c) <u> </u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u> | | | | 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 <u> </u> Month, Day, Year <u> </u> | | | | | |
| 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 <u>1-4-60</u> to <u>1-4-60</u> and last saw her <u>him</u> alive on <u>1-4-60</u> Death occurred at <u>7:40 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Paul W. Schaper M.D.</u> | | | 22b. ADDRESS <u>601 S. Brentwood, Clayton 5, Mo.</u> | | 22c. DATE SIGNED <u>1-5-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>1-7-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | | 23d. LOCATION (City, town, or County) (State) <u>Normandy, Mo</u> | |
| 24. FUNERAL DIRECTOR <u>White-Mullen Mortuary, Ferguson</u> | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>1-6-60</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> | |

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Reinhold K. Schmauer

Licensed Embalmer No. 3396

P. O. Address Sp/miss 35/ma

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.