

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 4 1960

60-013064

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3110** STATE FILE NUMBER

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis | | Length of stay in 1b | c. CITY OR TOWN Saint Louis |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION V. A. Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1431 N. Newstead |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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|-------------------------------------|---------------|--------|---------------|------------------|-----------|-------------|------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| | Alfred | | Perine | March | 16 | 1960 | |

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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-20-1917 | 9. AGE (last birthday) 42 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | 10b. KIND OF BUSINESS OR INDUSTRY Chain Company | 11. BIRTHPLACE (City and state or country) Shelby, Mississippi | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
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| 13a. FATHER'S NAME Edward Perine | 13b. MOTHER'S MAIDEN NAME UNKNOWN | 14. NAME OF HUSBAND OR WIFE Bertha Perine |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War II | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs. Bertha Perine | Address apt. E way 1241 N. Kinghigh |
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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: | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Lobar Pneumonia | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) | |
| DUE TO (b) Cardiac Arrest | |
| DUE TO (c) 5217 | |

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| 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I, PART II of item 18.) While undergoing operation for aortic aneurysm at Uptown Hospital on March 16, 1960 |
| 20c. TIME OF INJURY Hour 9 a.m. Month, Day, Year 3 16 60 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hosp |
| 20f. CITY, TOWN, OR LOCATION St Louis Mo | COUNTY | STATE |

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at **1040 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22. SIGNATURE (Degree or title) Joseph M. Smith, Jr. M.D. | 22b. ADDRESS 1300 Chestnut | 22c. DATE SIGNED 3-17-60 |
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|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Shipped | 23b. DATE 3-18-60 | 23c. NAME OF CEMETERY OR CREMATORY Shelby, Mississippi | 23d. LOCATION (City, town, or county) (State) |
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|--|--------------------------------|--|--|
| 24. FUNERAL DIRECTOR Metropolitan Funeral System, Inc. | ADDRESS 5010 Enright | 25. DATE RECD. BY LOCAL REG. MAR 17 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

operation for aneurysm of lung

STATEMENT BY LICENSED EMBALMER

_____ 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

John K. Cummings

Licensed Embalmer No. 4474

P. O. Address 2405 W. Main St.

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.