

FILED VS SEP 28 1960

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9190

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

NDED

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 St. Louis		c. CITY OR TOWN Crystal City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Hospital		d. STREET ADDRESS (If outside, give location) 303 Lindsay	

3. NAME OF DECEASED (Type or print) First Middle Last Philip Perryman			4. DATE OF DEATH Month Day Year Sept. 15, 1960		
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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 8-23-1903	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glassworker	10b. KIND OF BUSINESS OR INDUSTRY P.P.G.CO.	11. BIRTHPLACE (City and state or country) Festus, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME WM. PERRYMAN	13b. MOTHER'S MAIDEN NAME STELLA BAURICHTER	14. NAME OF HUSBAND OR WIFE DELIA
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT RONALD PERRYMAN FESTUS, MO.	Address
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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)	Cirrhosis of the Liver	
DO TO (b)	Chronic Endocarditis	
DO TO (c)	581.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)	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 checked="" 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.)
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20c. TIME OF INJURY Hour a.m. 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
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21. I attended the deceased from _____ to _____ and last saw him/her alive on _____
Death occurred at _____ **5:40 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul J. Simon	(Degree or Title) Deputy Coroner	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 9/16/60
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9-18-60	23c. NAME OF CEMETERY OR CREMATORY ROSELAWN MEMORIAL	23d. LOCATION (City, town, or county) CRYSTAL CITY, MO.
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24. FUNERAL DIRECTOR GENTRY RPOLITTE	ADDRESS CRYSTAL CITY, MO.	25. DATE RECD. BY LOCAL REG. SEP 19 1960	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0981 9 100

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

Gentry R. Polite

Licensed Embalmer No. 3481

P. O. Address Crystal

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.