

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-50-048627

FILED VS JAN 23 1961 75 Primary Registration District No. 3015 Registrar's No. 7

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>DeKalb</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Cameron</b>		Length of stay in 1b <b>week</b>		c. CITY OR TOWN <b>Fairport</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cameron Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Willard</b> Last <b>Peery</b>				4. DATE OF DEATH Month <b>12</b> - Day <b>26</b> - Year <b>60</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-10-1901</b>		9. AGE (last birthday) <b>59</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (City and state or country) <b>Fairport Mo</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>A.L. Peery</b>				13b. MOTHER'S MAIDEN NAME <b>Lennie Daniel</b>				14. NAME OF HUSBAND OR WIFE <b>Velma Peery</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>499-20-2874</b>		17. INFORMANT Address <b>Velma Peery Fairport 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>Primary adenocarcinoma Gallbladder</b> DUE TO (b) <b>Chronic Cholelithiasis &amp; cholecystitis</b> DUE TO (c) <b>Chronic</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> <b>25 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Disease, asthma, Hypertrophic aortic</b>										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 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 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		
21. I attended the deceased from <b>5-2-1960</b> to <b>12-26-60</b> and last saw her/him alive on <b>12-26-60</b> Death occurred at <b>11P</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Dr. F. Hetherington MD</b>						22b. ADDRESS <b>Cameron Mo</b>			22c. DATE SIGNED <b>1-16-61</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-29-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairport</b>				23d. LOCATION (City, town, or county) (State) <b>Fairport Mo</b>					
24. FUNERAL DIRECTOR <b>John Brown</b>					ADDRESS <b>Maysville Mo</b>		25. DATE RECD. BY LOCAL REG. <b>1-16-61</b>		26. REGISTRAR'S SIGNATURE <b>Francis Crawford</b>				

DOCUMENT

MEDICAL CERTIFICATION

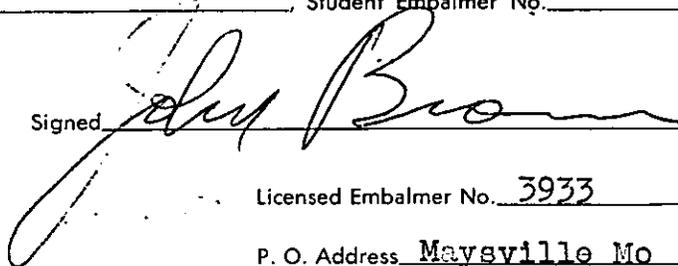
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed



Licensed Embalmer No. 3933

P. O. Address Maysville Mo

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.