MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-029050
STATE FILE NUMBER

AMENDED

Registration District No. 382 Primary Registration District No. 5545 Registrar's No. 14

FILED SEP 15 1961

1. PLACE OF DEATH
a. COUNTY: HOWARD
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: CHARITON TWP — Length of stay in 1b: 8 MOS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: RFD #1, GLASGOW — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: LINN
c. CITY OR TOWN: ST. CATHERINE — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): R.F.D. — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First JOSEPH Middle E. Last PERRIN
4. DATE OF DEATH: Month AUG. Day 29. Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: DEC. 10, 1878
9. AGE (last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (City and state or country): GAINESVILLE, TEX
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: JOHN PERRIN
13b. MOTHER'S MAIDEN NAME: MARTHA ANN STEVENS
14. NAME OF HUSBAND OR WIFE: ELLA FINNEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: CLAUDE PERRIN Address: ST. CATHERINE, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage c — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Rt. hemiplegia. — 4 days
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): fractured rt. hip.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Aug. 25-61, to Aug. 28-61 and last saw him alive on Aug 28-61
Death occurred at 3:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: [signature] (Degree or title) MD
22b. ADDRESS: Fayette Mo.
22c. DATE SIGNED: 8-29-61
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: AUG. 31, 1961
23c. NAME OF CEMETERY OR CREMATORY: PLEASANT VIEW
23d. LOCATION (City, town, or county) (State): ST. CATHERINE, MO.
24. FUNERAL DIRECTOR: WRIGHT FUNERAL HOME ADDRESS: BROOKFIELD, MO.
25. DATE RECD. BY LOCAL REG.: Aug. 30, 1961
26. REGISTRAR'S SIGNATURE: Walker Audsley
(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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_____ Signed Harold B. Wright

Signature of Student Embalmer

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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.