ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7796 STATE FILE NUMBER 61-031032

AMENDED

FILED AUG 28 1961

1. PLACE OF DEATH
a. COUNTY Jefferson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b: Life
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Kirkwood
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 844 So. Harrison
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Mack Middle E. Last Perkins
4. DATE OF DEATH: Month August Day 20, Year 1961
5. SEX: Male
6. COLOR OR RACE: Col.
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 4/18/04
9. AGE (last birthday): 57
IF UNDER 1 YEAR: Months 4 Days 2
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retirement
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA.
13a. FATHER'S NAME: August C. Perkins
13b. MOTHER'S MAIDEN NAME: Anna James
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
17. INFORMANT: August T. Perkins Address: 761 Walton Ave.

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) Acute renal failure — 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) Multiple kidney infarctions
DUE TO (c) Bilateral thrombosis of iliac arteries — Several yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 466X
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 8/7/61, to 8/20/61 and last saw her/him alive on 8/20/61
Death occurred at 6:40 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. O. Vermillion, M.D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 8/21/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/23/61
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: Wright Funeral Home ADDRESS: 3100 Easton Ave.
25. DATE RECD. BY LOCAL REG.: AUG 22 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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_____
Signature of Student Embalmer

Signed Arthur L. Hellhard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Av

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.