

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

33570

1. PLACE OF DEATH

County Henry Registration District No. 347
Township _____ Primary Registration District No. 3018
City Clinton No. 900 E Green

File No. _____
Registered No. 126
St. _____ Ward) _____

2. FULL NAME

Phoobe C Perry
(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J C Perry

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 20 1856

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>73</u>	<u>8</u>	<u>12</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer). in own home
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

PARENTS	10. NAME OF FATHER <u>Joseph M Cary</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana</u>
	12. MAIDEN NAME OF MOTHER <u>Smith</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana</u>

14. INFORMANT J C Perry
(Address) Clinton Mo

15. FILED Oct 14 1929 Dr. E. C. Reeler
m.c. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-12 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1929, to Oct 12 1929, and that I last saw him alive on Oct 1 1929, and that death occurred, on the date stated above, at 10:21 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Progressive paralysis
820 (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. S. Swalker, M. D.

10-12. 1929 (Address) Clinton Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Clinton Mo</u>	DATE OF BURIAL <u>Oct 13 1929</u>
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20. UNDERTAKER <u>Space & Son Clinton</u>	ADDRESS _____
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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



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