

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.

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

REC'D APR 12 1939

791  
1003

8891

Do not use this space.

2656

1. PLACE OF DEATH

- (a) County 2 Registration District No. \_\_\_\_\_  
 (b) Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (c) City St Louis (d) Street No. 821A N. Ewing St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mable Perry

- (a) Residence, No. 821A N. Ewing St. 21  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Pete Perry</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 9 - 1912</u>		
7. AGE YEARS <u>27</u>	MONTHS <u>2</u>	DAYS <u>8</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Domestic</u>		If LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as saw mill, bank, etc.		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Earl Ark</u>		
13. NAME <u>William Armour</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>? Ark.</u>		
15. MAIDEN NAME <u>Unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>? Unknown</u>		
17. INFORMANT <u>Pete Perry</u> (ADDRESS) <u>821A N. Ewing Ave</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Washington Park</u> DATE <u>3-21-1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>Ellis Funeral Home</u> (ADDRESS) <u>2820 Stoddard St</u>		
20. FILED <u>MAR 21 1939</u> <u>J. B. Bruders</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 17 1939

22. I HEREBY CERTIFY, That I attended deceased from 3 - 11 1939, to 3 - 17 1939

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_. Death is said

to have occurred on the date stated above, at 12:05 a. m.

The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_

(Signed) B. W. Bruders, M. D.

(Address) 2125 Y. Franklin

**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

*L. Boykin*  
*myself*

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed

*Lennie Boykin*

Licensed Embalmer No.

*2946*

P. O. Address

*St Louis 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 this body is not embalmed, above space should be left blank.**