

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4713

1. PLACE OF DEATH:

(a) County Jackson County
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 3411 Oakley
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jania Perkins

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex Female 5. Color or race negro
 6. (a) Single, widowed, married, divorced ✓
 6. (b) Name of husband or wife Wan Perkins 6. (c) Age of husband or wife if alive 48 years
 7. Birth date of deceased June 6 1884
(Month) (Day) (Year)

8. AGE: Years 55 Months 6 Days 2 If less than one day
hr. min.

9. Birthplace Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business —

MOTHER FATHER
 { 12. Name George Adams
 { 13. Birthplace Mississippi
 { 14. Maiden name Harriet Taylor
 { 15. Birthplace Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jan Perkins

(b) Address 3411 Oakley St

17. (a) Removal (b) Date thereof 12-12-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wascusko Miss.

18. (a) Signature of funeral director H. B. Moore

(b) Address 1820 E-18th St

19. (a) Dec. 12, 1939 (b) M. M. Brome
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3411 Oakley Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A. — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 8
 year 1939 hour 1230 minute A. M.

21. I hereby certify that I attended the deceased from Dec 31, 1931 to Dec 11, 1939

that I last saw her alive on Dec 11, 1939

and that death occurred on the date and hour stated above.

Immediate cause of death Of old age
g.w. Duration 42 days

Due to unknown

Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —

While at work? — (Specify type of place) (e) Means of injury —

23. Signature M. Miller (M. D. or other)

Address 1605 E 18th Mo. Date signed 12-12-39

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.

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES
REGISTERED EMBALMERS

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.....

AB Moore, Registered Apprentice No. _____
working under my personal supervision.

Signed AB Moore

Licensed Embalmer No. 2410

P. O. Address X-C. 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42304
Do not use this space.

1. PLACE OF DEATH *Jackson*
(a) County *Jackson* Registration District No. *399*
(b) Township *R. C.* Primary Registration District No. *1002* Registered No. *4913*
(c) City *R. C.* (d) Street No. _____ 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 *Janis Perkins*
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *♀* 4. COLOR OR RACE *Col* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 6 2

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED *Dec 12 1939 M. M. Brown*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-8-39*

22. I HEREBY CERTIFY, That I attended deceased from _____ 19__ to _____ 19__

I last saw him _____ alive on _____, 19__ Death is said to have occurred on the date stated above, at _____ m.

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

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? _____

If so, specify _____

(Signed) *D. M. Miller* _____ M. D.

(Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY
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