

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20066

State File No. _____

Registration District No. **7911**

Primary Registration District No. **1003**

Registrar's No. **5014**

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3533 Laclede, Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3533 Laclede, Ave. 21**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **4th**
year **1940** hour **11:40** minute **P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis; Cor Bovis;

Due to _____
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)
(a) Means of injury _____

23. Signature _____
Address _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

956

3. (a) PRINT FULL NAME **Ada Perkins** **625**
(b) If veteran, name war _____ (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Robert Perkins** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **September 20 1892**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 8 16 hr. min.

9. Birthplace **Unknown Louisiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Juleas Nicheols**

13. Birthplace **Unknown Louisiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Abbie Hynes**

15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Chas. Perkins**
(b) Address **3533 Laclede Ave.**

17. (a) **Burial** (b) Date thereof **6-10-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **E. H. Garner**

(b) Address **2829 Washington, Ave.**

19. (a) **JUN 8 1940** (b) **J. Predeck**
(Date received locally) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

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

Signed Robert H. Powell.

Licensed Embalmer No. 3402

P. O. Address 3100 Franklin.

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.