

FILED AUG 23 1940

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

25344

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 409  
 (b) Township Iron-De-Bar Primary Registration District No. 4237 Registered No. 13  
 (c) City Oak Grove Mo. 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 600 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

LENORE VIRGINA PERRY  
 (a) Residence, No. Oak Grove Mo. (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 Female 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elmer H. Perry.  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 5, 1895  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 4 23  
 OCCUPATION 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. house wife  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation all

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. C., Mo.

FATHER 13. NAME George O. Dewey

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

MOTHER 15. MAIDEN NAME Minnie Wilson

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

17. INFORMANT (ADDRESS) Mary Anna Perry Oak Grove Mo.

18. BURIAL, CREMATION, OR REMOVAL Oak Grove Crematory DATE 6/30 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Howe Oak Grove Mo.

20. FILED July 10, 1940 Mrs. A. V. Mann Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-28-1940

22. I HEREBY CERTIFY, That I attended deceased from April 19, 1940, to 6-28, 1940

Last saw her alive on 6-28, 1940. Death is said to have occurred on the date stated above, at 11:40 P.M.

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

Hypostatic Pneumonia Date of onset 6-28-40

Other contributory causes of importance Articular Rheumatism 4-19-40  
From infected tooth

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) E. H. Perry, M. D.

(Address) Oak Grove Mo.

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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,

*Z. Webb*

, or by

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

Signed

*Z. Webb*

Licensed Embalmer No. *2352*

P. O. Address *Oak Grove, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25-344

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 402

Primary Registration District No. 4237

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Rose Virginia Perry  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
(b) Name of husband or wife \_\_\_\_\_ (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
45 4 23 \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH month 6 day 28  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 Hypostatic pneumonia Duration \_\_\_\_\_  
Due to # Bronchial # 107W  
Due to \_\_\_\_\_

Other conditions Articular Rheumatism  
(Include pregnancy within 3 months of death)

Major findings: Infected tooth PHYSICIAN  
Underline the cause to which death should be charged statistically.

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?

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

23. Signature E. E. Perry (M. D. or other) \_\_\_\_\_  
Address Dale Grove Date signed \_\_\_\_\_

SUPPLEMENTAL COPY

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

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