

DIED OCT 18 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33432**

Registration District No. **908**

Primary Registration District No. **4549**

Registrar's No. **50**

1. PLACE OF DEATH:

(a) County **Wright**
(b) City or town **Mt. 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 **20**
In this community **Ten years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Wright**
(c) City or town **Mt. Grove**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **9**
year **1940** hour **7** minute **P.M.**

21. I hereby certify that I attended the deceased from **9/11 -**
1940, to **9/9 -** 1940;

that I last saw her alive on **9/9 -** 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death **entero cholera**

Duration

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underlines 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? _____

While at work? **831** (Specify type of place)
(e) Means of injury _____

23. Signature **R A Ryan** (M. D. or other) _____
Address **Miss Grand** Date signed **9/20/40**

3. (a) PRINT FULL NAME **MARY FLORENCE PERKEY**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **S.O.** 6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **MARCH 3 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 6 10 hr. min.

9. Birthplace **White County Ill**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Thomas C. Orr**

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

14. Maiden name **Honey Helen Salla**

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

16. (a) Informant **S. O. Perkey**

(b) Address **Mt Grove, Mo**

17. (a) **Burial** (b) Date thereof **Sept 18, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lone Star**

18. (a) Signature of funeral director **Russell Barber**

(b) Address **Mt Grove Mo**

19. (a) **9-25-40** (b) **Bekure Montgomery**
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 6r

District File Number. 1040-2747

Date Filed OCT 17 1940

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 Russell Barber

Licensed Embalmer No. 3848

P. O. Address Mt. Hope 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.