

S. No. 2
1-542
-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8667**
Registrar's No. **2940**

FILED APR 3 1943 8
Registration District No. **1003**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay in hospital or institution **7 days**
In this community **6 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis,** (If outside city or town limits, write "RURAL") **17**
(d) Street No. **928 N. 15th St.** (If rural, give location) **9 25**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **Carrie Perkins**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Sullivan Perkins** 6. (c) Age of husband or wife if alive **7** years

7. Birth date of deceased **Dec 25 - 1900** (Month) (Day) (Year)

8. AGE: Years **42** Months **2** Days **28** If less than one day hr. min.

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

10. Usual occupation **House wife**

11. Industry or business

12. Name **Wilard Calmeace**

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

14. Maiden name **Church**

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

16. (a) Informant **Wilard Calmeace**

(b) Address **4208 W. Finney**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **March 19/43** (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Edward Funeral Home** (Specify type of place) (b) Address **215 So. Jefferson** (c) Means of injury **0**

19. (a) **MAR 29 1943** (Date received local registrar) **J. F. Budeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **23** year **1943** hour **12** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **March 16,** 19**43**, to **March 23,** 19**43**;

that I last saw her alive on **March 23,** 19**43**; and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease** Duration **Unknown**

Due to **9/2**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

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) (e) Means of injury

23. Signature **J. E. Smith** (M. D. or other) Address **2601 W. 15th St.** Date signed **3/24/43**

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

MOTHER FATHER

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.....

Licensed Embalmer No. *2698*

P. O. Address. *2769 Chouteau*

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, fact should be so stated above.