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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John Hosp. 0
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 1 1/2 Days (Specify whether
In this community 1 1/2 Days years, months or days)

3. (a) PRINT FULL NAME Jo Lane Perdue
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Male: ied 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 9 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Murry L. Perdue
13. Birthplace Montgomery Alabama
(City, town, or county) (State or foreign country)
14. Maiden name Betty Jo. Baucher
15. Birthplace Wentworth Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Betty Jo. Perdue
(b) Address Pierce City, Mo.
17. (a) Burial (b) Date thereof 1/7/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pierce City, Mo.

18. (a) Signature of funeral director Wilks Bros
(b) Address Pierce City, Mo.
19. (a) 1-8-47 (b) W.E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lawrence
(c) City or town Pierce City, Mo. (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 6
year 1947 hour 1 minute 20 P.M.
21. I hereby certify that I attended the deceased from 1-4 1947, to 1-6 1947
that I last saw him alive on 1-6-47 and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis, pneumonia Duration 2 weeks
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy Meningitis
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 J.P. Schwank (M. D. or other) _____
Address 420 Med. Bldg. Springfield Date signed 1-6-47

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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, or by.....

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

This body not embalmed.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.