

S. No. 2
M-5-43
v. 5-17-39
I X36571

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24909**
Registrar's No. **222**

FILED JUL 16 1947
Registration District No. **238**

Primary Registration District No. **5822**

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

1. PLACE OF DEATH:

(a) County **New Madrid**

(b) City or town **Rural - Huff township**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community: **Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **New Madrid**

(c) City or town **Rural** (If outside city or town limits, write "RURAL")

(d) Street No. **20 miles N. East New Madrid, Mo.** (If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **JOSEPH PERIDORE**

3. (b) If veteran, name war **-**

3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **13** year **1947** hour **11:50** minute **9** M.

21. I hereby certify that I attended the deceased from **Mich!** 1947 to **June 13** 1947; that I last saw him alive on **June 13** 1947; and that death occurred on the date and hour stated above.

Immediate cause of death _____

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

(b) Name of husband or wife **Rosa Peridore** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **July 10, 1863**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	11	3	hr. min.

Gangrene Leg **IMO**

Due to **arterio-sclerosis** **6 yrs**

Other conditions (include pregnancy within 3 months of death) _____

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

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **John A. Peridore** **5**

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

14. Maiden name **Unknown** **9**

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

Major findings: Of operations _____

Of autopsy **97**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Sily Bolden**

(b) Address **Matthews, Mo. Rt. 2**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6-16-47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Dogwood Plains Shelby**

18. (a) Signature of funeral director **East Prusse, Mo.**

(b) Address **7-9-47**

19. (a) **7-9-47** (Date received local registrar) (b) **Nelson Lamb Jones** (Registrar's signature)

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)

(e) Means of injury _____

23. Signature **A. P. Martin** (M. D. or other) **0**

Address **E. Grassie, Mo.** Date signed **7-3-47**

RECEIVED
District Health Office No. 2,
District File Number 242-923
Date Filed 2-14-47

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.....

Travis Shelby

Licensed Embalmer No. 2726

P. O. Address East Prairie 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, fact should be so stated above.