

FILED MAY 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12625

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>405</u>		
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield,</u>		c. LENGTH OF STAY (In this place) <u>1 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Republic Republic Twp</u>		AD		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trotter Nursing Home 615 N. Main</u>				d. STREET ADDRESS (If rural, give location) <u>031</u>				
3. NAME OF DECEASED a. (First) <u>James</u>			b. (Middle) <u>Constantine</u>		c. (Last) <u>Perkins</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 27, 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 7, 1872</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired City Marshall</u>		11. BIRTHPLACE (State or foreign country) <u>Greene Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Peter G. Perkins</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Jane Rose</u>		14. NAME OF HUSBAND OR WIFE <u>Fronia Perkins</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John Crumpley, R 1 Marionville, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senile Dementia</u>				DUE TO (b) <u>old Cerebral Hemorrhage</u>				331X
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Analyzed it said - Suffered from</u>				DUE TO (c) <u>arteries much turned from</u>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR _____				
22. I hereby certify that I attended the deceased from <u>Several</u> calls, 19 <u>50</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>50</u> and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.								
22a. SIGNATURE <u>Garrett Haggard, M.D.</u> (Degree or title) <u>0</u>				22b. ADDRESS <u>1053 Roanoke</u>		22c. DATE SIGNED <u>5-3-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Apr. 29, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Marionville, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>5-4-50</u>		REGISTRAR'S SIGNATURE <u>W.S. Hand Equin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Hurdidge</u>		ADDRESS <u>Marionville, Mo.</u>		

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Ferman Hurridy

Licensed Embalmer No. *3072*

P. O. Address *Marionville*

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.