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FILED OCT 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32586

State File No.

BIRTH NO. _____ REG. DIST. NO. 73 PRIMARY REG. DIST. NO. 5291 Registrar's No. 84

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>LIBERTY-RURAL</u>		c. CITY OR TOWN <u>EXCELSIOR SPRINGS</u>	
c. LENGTH OF STAY (in this place) <u>3 DAYS</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>I.O.O.F. HOME</u>		e. STREET ADDRESS (If rural, give location) <u>210 TEMPLE</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARTHA</u>	b. (Middle) <u>JANE</u>	c. (Last) <u>PERKINS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 6 1955</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 11, 1855</u>	9. AGE (In years last birthday) <u>100</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>CENTERVILLE, IOWA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>WILLIAM SPARKS</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>EMORY LEWELLAN PERKINS</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>IVA HANKINS. 210 TEMPLE EX. SPRINGS, MO.</u>
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Haemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) <u>331X</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 checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 3, 1955, to Oct 6 1955, that I last saw the deceased alive on Oct 5, 1955, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm. G. Goodson M.D.</u>	23b. ADDRESS <u>Liberty Mo</u>	23c. DATE SIGNED <u>10/7/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>10-8-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>BRAYMER CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>BRAYMER Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Oct 8, 1955</u>	REGISTRAR'S SIGNATURE <u>Mabel Fra Laine</u>	491 - FUNERAL DIRECTOR'S SIGNATURE <u>Clarence Prichard</u>	ADDRESS <u>Excelsior Springs Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Lindell Jarmann*.....

Licensed Embalmer No. *45*.....
Excelsior Springs
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.