

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41359

State File No.

FILED JAN 3 - 1956

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 383

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. CITY OR TOWN <u>Hannibal</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>1 mo.</u>		e. STREET ADDRESS (If rural, give location) <u>117 O'Fallon</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>KATIE</u>	b. (Middle) <u>B.</u>	c. (Last) <u>PERKINS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12-18-55</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>June 23, 1866</u>	9. AGE (In years, last birthday) <u>89</u>	If UNDER 1 YEAR Months _____ Days _____	If UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Burlington, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>William Short</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Maddox</u>	14. NAME OF HUSBAND OR WIFE <u>Andrew M. Perkins (Dec.)</u>
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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. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Robie Wilson, Hannibal, 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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis, generalized</u> DUE TO (c) <u>Hypertensive Cardio-vascular disease 44 3/4 years</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) <u>Hannibal, Marion Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 11/15/55 to 12/18/55, 1955, that I last saw the deceased alive on 12/12/55, 1955, and that death occurred at 5:40 P m., from the causes and on the date stated above.

23a. SIGNATURE (Dress or title) <u>J. H. Watuschek M.D.</u>	23b. ADDRESS <u>Hannibal Mo.</u>	23c. DATE SIGNED <u>Dec 20, 55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-21-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Moberly, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>12/20/55</u>	REGISTRAR'S SIGNATURE <u>H. E. Luhe</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jack Schwart - Hannibal, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED DEC 29 1955
MARION CO. HEALTH DEPT.
DATE FILED DEC 29 1955

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 *Jack Schwartz*.....
Licensed Embalmer No. *4900*.....

P. O. Address *Hannibal*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. _
If this body is not embalmed, fact should be so stated above.