

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 6 - 1956

State File No. **11250**  
Registrar's No. **3069**

BIRTH NO. \_\_\_\_\_ REG.-DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>		c. CITY OR TOWN <b>St Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>3 yrs</b>		e. STREET ADDRESS (If rural, give location) <b>4558 Ray</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4558 Ray</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Charles</b>	b. (Middle) <b>Stewart</b>	c. (Last) <b>Perry</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Mar. 24, 1956</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Aug 4, 1873</b>	9. AGE (In years) (last birthday) <b>82</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Chariton, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John W Perry</b>	13b. MOTHER'S MAIDEN NAME <b>Henrietta Funk</b>	14. NAME OF HUSBAND OR WIFE <b>deceased</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs G W Schwartz</b>	ADDRESS <b>Rt 1 E. Aurora, N.Y.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH: <b>5 mo</b>  <b>49 years</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma Stomach</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Nephritis</b> DUE TO (c)		
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 <b>151x</b>	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) (m.)	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 Sep 7, 1955 to March 24, 1956, that I last saw the deceased alive on March 27, 1956, and that death occurred at 8:45 P. m., from the causes, and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Walter Shelley MD</b>	23b. ADDRESS <b>995 Gravois</b>	23c. DATE SIGNED <b>March 26, 1956</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3/27/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Vaihalla Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis County Mo.</b>
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DATE REC'D BY LOCAL REG. <b>MAR 27 1956</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J L Ziegenhein &amp; Sons</b>	ADDRESS <b>7027 Gravois</b>
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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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *G. P. Kidwell*

Licensed Embalmer No. *387*

P. O. Address *7027 St*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.