

Health, Welfare Public Service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30895

STATE FILE NUMBER

FILED OCT 3 1956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4126

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2536 Michigan</u>		Length of stay in lb <u>1 1/2 yrs. 3</u> STREET ADDRESS (If outside, give location) <u>398 2536 Michigan</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>IRVIN</u> Middle <u>ROLLAND</u> Last <u>PERKINS</u>			4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2, 1895</u>		9. AGE (In years last birthday) <u>61 yrs.</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fox Midwest</u>		11. BIRTHPLACE (City and state or country) <u>Fulton, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Thaddeus Perkins</u>		
14. MOTHER'S MAIDEN NAME <u>Luellen Evahart</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>490-07-4078</u>			17. INFORMANT Address <u>Lorraine Perkins 2536 Michigan</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Ht Disease</u>	<u>3 yrs</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular Fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Hour <u>no</u> Month <u>no</u> Day <u>no</u> Year <u>no</u> a. m. p. m.		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>	20f. CITY, TOWN, OR LOCATION <u>Fulton</u>	COUNTY <u>Fulton</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>1-29-56</u> and last saw her alive on <u>9-19-56</u> Death occurred at <u>1:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>J. S. Wells M.D.</u>		22b. ADDRESS <u>2122-E-15</u>		22c. DATE SIGNED <u>9-20-56</u>

23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/23/56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fulton</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Watkins Bros. Fn. Hm. 18th & Benton</u>		25. DATE RECD. BY LOCAL REG. <u>9-21-56</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
J. S. Wells

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 *Bruce R. Watkins*

Licensed Embalmer No. *45*

P. O. Address *18th & B*

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.