

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All diseases to be symptoms written as listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 29 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38367

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 520

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence Missouri</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Wellington, Missouri</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Crestview N. E. 416 E. College - R H</b>			Length of stay in 1b <b>3 Weeks</b>		d. STREET ADDRESS (If outside, give location) <b>0</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Otis</b> Last <b>Perrine</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>22</b> Year <b>1956</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 26 1870</b>		9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Lafayette County, Mo</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S</b>					
13. FATHER'S NAME <b>Jim Perrine</b>						14. MOTHER'S MAIDEN NAME <b>Mary Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, cite war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mrs. Gussie Krause 5409 Euclid K. C. Mo</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Prostate</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) _____			
										DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)										
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from <b>Nov. 2, 1956</b> to <b>Nov. 22, 1956</b> and last saw <del>her</del> <sup>him</sup> alive on <b>Nov. 21, 1956</b> Death occurred at <b>8:45 Pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Shank Shabake, M.D.</b>						22b. ADDRESS <b>Independence, Mo.</b>			22c. DATE SIGNED <b>11/23/56</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov 24 1956</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>			23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>						
24. FUNERAL DIRECTOR ADDRESS <b>FLORAL HILLS MEMORIAL CHAPEL INC K.C.MO</b>				25. DATE RECD. BY LOCAL REG. <b>11-24-56</b>		26. REGISTRAR'S SIGNATURE <b>James Craig</b>							

*Dr. Grubbs  
Phys. Med. Bldg  
Emp. Univ. of Wash. Rd.  
Indep. City, Mo. 64*

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 *Everett L. Seel*.....

Licensed Embalmer No. *48*

P. O. Address *7. 2nd 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.