

Health,
& Welfare
Public
Service

S. 300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| HEALTH OF MISSOURI | | | STANDARD CERTIFICATE OF DEATH | | | STATE FILE NUMBER | | | | | |
|--|-------------------------------|---|--|---|---|---|--|--|----------------------------|--|--|
| FILED JUN 10 1957 | | | Registration District No. <u>47</u> | | | Primary Registration District No. <u>3008</u> | | | Registrar's No. <u>147</u> | | |
| 1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CALLAWAY</u> | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FULTON</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>FULTON</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSPITAL #1</u> | | | Length of stay in lb <u>12 DAYS</u> | | d. STREET ADDRESS (If outside, give location) <u>2143</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Chose</u> First <u>Perry</u> Middle Last | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1957</u> | | | | | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-27-07</u> | | 9. AGE (In years last birthday) <u>49</u> | 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) <u>UNKNOWN</u> | | | 10b. KIND OF BUSINESS OR <u>UNKNOWN</u> | | 11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 13a. FATHER'S NAME <u>UNKNOWN</u> | | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | 14. NAME OF HUSBAND OR WIFE <u>*****</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (Yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT Address <u>STATE HOSPITAL #1, FULTON, MISSOURI</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>GENERALIZED CARCINOMATOSIS</u> DUE TO (b) <u>CARCINOMA OF LEFT BREAST</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>170x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>LIVER CIRRHOSIS</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 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 <u>May 22-57</u> to <u>6-5-57</u> and last saw her/him alive on <u>6-5-57</u> Death occurred at <u>3:50 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Wm. J. Cremer, M.D.</u> | | | | | 22b. ADDRESS <u>State Hosp</u> | | | 22c. DATE SIGNED <u>6-5-57</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY. | | | 23d. LOCATION (City, town, or county) (State) | | | | | |
| <u>Burial</u> | | <u>June 7, 1957</u> | <u>1 Hillcrest</u> | | | <u>Fulton Mo</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Marquette Funeral Home</u> | | | ADDRESS <u>Fulton Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>June 8-1957</u> | | 26. REGISTRAR'S SIGNATURE <u>Maritta Lawrence</u> | | | | |

16378

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 *J. D. Rossom*
Licensed Embalmer No. *7555*

P. O. Address *Hilton*

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.