

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005801

STATE FILE NUMBER

525

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 525

Health, Welfare
Public
Service

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cass	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Pleasant Hill	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		d. STREET ADDRESS Rt. 4	
3. NAME OF DECEASED (Type or print) First Middle Last Donna Kay Perry		4. DATE OF DEATH Month Day Year January 24th, 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		11. BIRTHPLACE (City and state or country) Harrisonville, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Donald E. Perry		13b. MOTHER'S MAIDEN NAME Barbara Cummins	14. NAME OF HUSBAND OR WIFE - - -
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address \$/Sgt D.E. Perry, Route 4, Pleasant Hill
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar pneumonia with emphysema, left.</i> 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)			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 <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 <i>1/22/59</i> to <i>1/25/59</i> and last saw her ^{her} _{him} alive on <i>1/24/59</i> Death occurred at <i>8:50</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Marvin D. Bordy, M.D.</i>		22b. ADDRESS <i>701 E 63 K.C. Mo.</i>	
		22c. DATE SIGNED <i>1/27/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>1-27-59</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Prairie Rose Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Corning Iowa</i>	
24. FUNERAL DIRECTOR ADDRESS <i>E.K. George & Sons Inc, Grandview Mo</i>		25. DATE RECD. BY LOCAL REG. <i>1-27-59</i>	
		26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>	

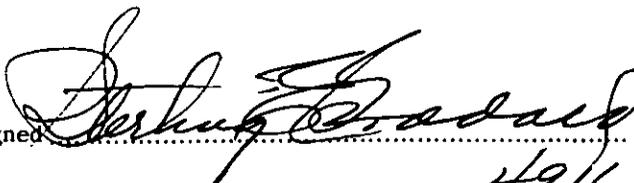
All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Marvin D. Bordy

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 

Licensed Embalmer No. 4911
P. O. Address Grandview

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.