

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017902

STATE FILE NUMBER

FILED MAY 29 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2222

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 Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen Hosp #1		Length of stay in. 1b 4 months	d. STREET ADDRESS (If outside, give location) 3112 E. 10th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alice Middle Matilda Last Perry			4. DATE OF DEATH Month 5 Day 3 Year 59		
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2- DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 20, 1874	
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) DeWitt, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Samuel Teeter		13b. MOTHER'S MAIDEN NAME Sarah K. Jenkins		14. NAME OF HUSBAND OR WIFE Jessie Perry Perry	
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 Perry Address RR#2 Mr. Clyde Perry, Excelsior Springs, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Heart Disease					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200					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.)			
20c. TIME OF INJURY Hour _____ 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 5-2-59 , to 5-3-59 and last saw her/him alive on 5-3-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Abraham Galperin (Degree or title) _____			22b. ADDRESS Gen. Hosp. #1, Kansas City, Mo.		22c. DATE SIGNED 5-3-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-3-59	23c. NAME OF CEMETERY OR CREMATORY Enon Cemetery		23d. LOCATION (City, town, or county) (State) Excelsior Springs, Missouri	
24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. Excelsior Springs, Missouri		25. DATE RECD. BY LOCAL REG. 5-4-59	26. REGISTRAR'S SIGNATURE Neva Minshall		

All diseases in Part I must be causally related.
Abraham Galperin M. D.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Lowell Jarman*

Licensed Embalmer No. *4589*
P. O. Address *Excelsior Springs, Mo.*

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.