

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-028028

STATE FILE NUMBER

FILED VS AUG 25 1959

Registration District No. 4 Primary Registration District No. \_\_\_\_\_ Registrar's No. 78

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock-Port mo</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fairfax Hospital</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>003 8<sup>o</sup></u>
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>Oliver</u> Last <u>Perry</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</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>July 12 - 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>77</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u> IF UNDER 24 HRS. Hours <u>   </u> Min. <u>   </u>
11a. FATHER'S NAME <u>William Perry</u>		11b. MOTHER'S MAIDEN NAME <u>Unknown</u>	11c. NAME OF HUSBAND OR WIFE <u>Mrs. Stella Perry</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>no</u>	17. INFORMANT Address <u>Mrs. Stella Perry - Rock-Port mo</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>Hypostatic Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchiectasis, Pulmonary emphysema &amp; fibrosis</u>			<u>15 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>524x</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>524x</u>	
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>July 52</u> to <u>8-17-59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>8-17-59</u> Death occurred at <u>8:45 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deed or title) <u>Wallace Carpenter mo</u>		22b. ADDRESS <u>Rock Port mo</u>	22c. DATE SIGNED <u>8-19-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>burial Aug 19/1959</u>		<u>Smith cemetery</u>	<u>N.E. Rock-Port mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Bethune Funeral Home - Rock-Port mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 21, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Thermin E. Hatcher</u>

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

MEDICAL CERTIFICATION

3-0

Embalmer's Statement on Reverse Side

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~~ ..... *C. E. Bertram* ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *C. E. Bertram* .....  
*by wife*

Licensed Embalmer No. *1724* .....

P. O. Address *Rock-pond* .....

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.