

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046712

LED VS DEC 2 9 1960

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 130

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in 1b <u>103</u> days	c. CITY OR TOWN <u>Carthage</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1006 Oak</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Matt</u> Middle <u>E.</u> Last <u>Periman</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1960</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>10-23-93</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Health Inspector</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>City</u>	11. BIRTHPLACE (City and state or country) <u>Dade County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Thomas Jefferson Periman</u>	13b. MOTHER'S MAIDEN NAME <u>Docia Dellia Robinson</u>	14. NAME OF HUSBAND OR WIFE <u>Maggie Periman</u>
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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>558-32-6622</u>	17. INFORMANT Address <u>San. records, Mo. State San., Mt. Vernon, Mo.</u>
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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>Acute broncho-pneumonitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24</u> hours
DUE TO (b) <u>acute hemorrhagic mediastinitis (post-operative) and acute pseudomembranous ileitis</u>		<u>48</u> hours
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary tuberculosis Far</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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Advanced, Active

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from 9 - 20 - 60 to 12-22-60 and last saw him alive on 12 - 22 - 60
Death occurred at 8:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MS</u>	22b. ADDRESS <u>Mt. Vernon, Mo.</u>	22c. DATE SIGNED <u>12-22-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Carthage, Mo.</u>
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24. FUNERAL DIRECTOR <u>Max L. Fousett</u> ADDRESS <u>Mt. Vernon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-24-60</u>	26. REGISTRAR'S SIGNATURE <u>H. D. Fousett</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 12 1968

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed May L. Fournell

Licensed Embalmer No. 4252

P. O. Address Milwaukee

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.