

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-016914

STATE FILE NUMBER

Registration District No. 238 Primary Registration District No. 5823 Registrar's No. 24

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 14 1963

New Madrid

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>New Madrid</u>		c. CITY OR TOWN <u>New Madrid</u>	
Length of stay in 1b <u>63 yrs</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>In. New Madrid</u>		d. STREET ADDRESS (If outside, give location) <u>Reside on Farm</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jess</u> Middle <u>P.</u> Last <u>Perkins</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1963</u>	
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>6-11-1872</u>
9. AGE (last birthday) <u>90</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Printer/Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Anna, Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Perkins</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Simmons</u>		14. NAME OF HUSBAND OR WIFE <u>Zara Perkins</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>		17. INFORMANT Name <u>Zara Perkins</u> Address <u>New Madrid, 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>Cerebral Hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterio-sclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. Month, Day, Year _____			
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 _____
21. I attended the deceased from <u>4-20-63</u> to <u>5-7-63</u> and last saw him alive on <u>5-7-63</u> Death occurred at <u>9:10</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James O. Cameron M.D.</u>		22b. ADDRESS <u>Lelbourn, Mo.</u>	22c. DATE SIGNED <u>5-9-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-10-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Advance Cemetery</u>	23d. LOCATION (City, town, or county) <u>Advance, Mo.</u>
24. FUNERAL DIRECTOR Name <u>Lloyd Russell Figgatt</u> Address <u>Adv.</u>		25. DATE REGD. BY LOCAL REG. <u>5/8/63</u>	26. REGISTRAR'S SIGNATURE <u>Fay Helguth</u>

VS 300
Rev. 4/59

1 0721
2 0721
3 2
4 0
5 1
6
7 1
8 2
9 331X
10
11
12 90-2
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

