

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-029049**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 174 Primary Registration District No. 3031 Registrar's No. 65

**FILED JUL 29 1963**

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
1 0547				
2 2547.2				
3				
4 3				
5 1				
6				
7 0				
8 2				
9 153.8				
10				
11				
12 2-0				
13 3-0				
	SHOULD READ	BY AFFIDAVIT OF	MEDICAL CERTIFICATION	ITEM NO.

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		c. CITY OR TOWN <u>Lexington</u>	
Length of stay in 1b <u>1 Week</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>Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>310 N 24 Street</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary M Perry</u>			4. DATE OF DEATH Month Day Year <u>July 7 1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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 16 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeper</u>	9. AGE (last birthday) <u>84</u>
11a. FATHER'S NAME <u>Jack Johnson</u>		11b. MOTHER'S MAIDEN NAME <u>Mallinda Smith</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <u>John W. 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>[REDACTED]</u>	
17. INFORMANT <u>John Perry 310 No 24 St Lexington Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>With Metastasis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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>1956</u> to <u>7,7,63</u> and last saw her/him alive on <u>7,7,63</u> Death occurred at <u>9:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joe W. Woodard</u>		22b. ADDRESS <u>Lexington Mo</u>	
22c. DATE SIGNED <u>7,9,63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 10 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Muncies Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Higginville Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>George H Green Fulton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-10-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

7-10-63 Burial permit issued

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 CHARLES R Williams, Student Embalmer No. 693

working under my personal supervision.

Student Charles R Williams  
Signature of Student Embalmer

Signed Georgette Green

Licensed Embalmer No. 4220

P. O. Address Jackson, 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.