

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032839

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 385 Primary Registration District No. 30384 Registrar's No. 454

FILED AUG 28 1963

VS 300
Rev. 4/59

1 0585
2 0210
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Charlton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield		Length of stay in 1b 4-Days	c. CITY OR TOWN Keytesville, Mo Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pershing Memorial Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 405-North St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LAFAYETTE H. PERRY			4. DATE OF DEATH Month Day Year AUG. 18th, 1963			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-20-1897	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) SPRINGFIELD, ILL.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME AMBROSE PERRY		13b. MOTHER'S MAIDEN NAME ELLEN FULLER		14. NAME OF HUSBAND OR WIFE DONA MEDLIN PERRY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of NO)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. DONA PERRY, KEYTESVILLE, MO.	

18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: Bronchovell IMMEDIATE CAUSE (a) Stroke		INTERVAL BETWEEN ONSET AND DEATH 4 days
103 Leimia		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) _____		

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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 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 _____ to _____ and last saw her/him alive on _____
Death occurred at **4:40 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B. D. Duffield M.D. (Degree or title)	22b. ADDRESS Brookfield Mo	22c. DATE SIGNED 8-19-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG. 20TH, 1963	23c. NAME OF CEMETERY OR CREMATORY ASBURY CEMETERY	23d. LOCATION (City, town, or county) (State) CHARLTON COUNTY, MO.
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24. FUNERAL DIRECTOR ADDRESS H. D. GARNETT, KEYTESVILLE, MO.	25. DATE RECD. BY LOCAL REG. 8-19-63	26. REGISTRAR'S SIGNATURE Gene Watson
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USE BLACK INK OR TYPEWRITER RIBBON

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 *H. D. Garrett*

Licensed Embalmer No. 3046

P. O. Address *Keytesville 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.