

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036336**

**FILED VS NOV 1 0 1959**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5189 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Kansas City</b>		Length of stay in 1b <b>10 yrs</b> <del>30 days</del>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>615 East 9th Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Perry</b> Middle <b>Scott</b> Last <b>Perry</b>			4. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>1959</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-17-1891</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baseball Player</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Baseball</b>	11. BIRTHPLACE (City and state or country) <b>Dennison, Texas</b>	12. CITIZEN OF WHAT COUNTRY <b>Usa</b>
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13a. FATHER'S NAME <b>Unk.</b>	13b. MOTHER'S MAIDEN NAME <b>Unk.</b>	14. NAME OF HUSBAND OR WIFE <b>Beulah Perry (dec.)</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>420-05-0712</b>	17. INFORMANT <b>William Gibons</b> Address <b>Independence, Missouri</b>
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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) <b>Broncho-pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH
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

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.)
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 **10-10-** to **10-27-1959** and last saw ~~him~~ <sup>her</sup> alive on **10-27-1959**  
Death occurred at **10:55 A.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Abraham Gelpin M.D.</b>	22b. ADDRESS <b>2400 Cherry Kansas City, Mo.</b>	22c. DATE SIGNED <b>10-27-59</b>
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23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 29, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Independence, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Geo. C. Carson &amp; Sons-Indep., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-28-59</b>	26. REGISTRAR'S SIGNATURE <b>Blva Marshall</b>
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DOCUMENT

BY AFFIDAVIT OF **Abraham Gelpin M. D.** MEDICAL CERTIFICATION