No. 2
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17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31501

FILED OCT 5 - 1943

Registration District No. 77 | Primary Registration District No. 3016 | Registrar's No. 195

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Cole
(b) City or town: Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 0 (Specify whether years, months or days)
In this community: 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Maries
(c) City or town: Vienna, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No.:
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

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0
0

3. (a) PRINT FULL NAME: Dean Ford Pearson
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: -- 0
6. (b) Name of husband or wife: --
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: July (Month) 30 (Day) 1943 (Year)
8. AGE: Years | Months: 1 | Days: 19 | If less than one day: hr. min.
9. Birthplace: Freeburg, Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation: --
11. Industry or business: --
MOTHER FATHER
12. Name: Grover J. Pearson
13. Birthplace: Can Cleve, Mo. (City, town, or county) 0 (State or foreign country)
14. Maiden name: Ethel McDonald
15. Birthplace: Argyle, Mo. (City, town, or county) 0 (State or foreign country)
16. (a) Informant: Grover J. Pearson
(b) Address: Vienna, Mo.
17. (a) Removal&Burial (Burial, cremation, or removal) (b) Date thereof: 9-21-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Vienna, Mo.
18. (a) Signature of funeral director: L. C. Cunningham
(b) Address: Vienna Mo
19. (a) Sept. 20, 1943 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 19 year 1943 hour 11 minute P M.
21. I hereby certify that I attended the deceased from Sept 14th, 1943 to Sept 19th, 1943 that I last saw him alive on Sept 19 (8 pm), 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Dilatation of Heart	1 Day
Due to Marasmus	1 Mo.
Due to Pylorus Stenosis	Since Birth
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 158
Of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: J. B. Krause MD (M. D. or other)
Address: Jefferson City Mo Date signed: 9/22-1943

894

(Licensed Embalmer's Statement on Reverse Side) Dr. Krause

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 Not Embalmed, Registered Apprentice No. ..... working under my personal supervision.

X Signed [illegible]

Licensed Embalmer No. 3664

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. act

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 195

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson city
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Dean Ford Pearson

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased July (Month) 30 (Day) 1943 (Year)

8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) mo (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) Norma Richter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

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