

No. 2
-8-43
5-17-39
K37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16940

State File No. _____

Registration District No. 122

Primary Registration District No. 5455

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic R.F.D. No. 1
(If outside city or town limits, write "RURAL" and name of township)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Republic - Rural
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Freda Lee Pearce

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Floyd Pearce 6. (c) Age of husband or wife if alive 35 years

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

8. AGE: Years 32 Months 10 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation House Wife

11. Industry or business _____

12. Name Bert Robertson

13. Birthplace _____ (City, town, or county) (State or foreign country) 7

14. Maiden name Alpha Kyle

15. Birthplace _____ (City, town, or county) (State or foreign country) 7

16. (a) Informant Floyd Pearce

(b) Address Republic R.F.D.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Lindsey Cemetery

18. (a) Signature of funeral director R.E. Thurman, Ltd. Co.

(b) Address Republic, Mo.

19. (a) 6/18/45 (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1945 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from No Physician in attendance 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Smoking Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 1640

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) Smoking

(b) Date of occurrence May 16, 1945

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place) (e) Means of injury Shot gun

23. Signature Wm. C. Stone (M. D. or other) corner

Address Springfield, Mo Date signed 5-16-45

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

MOTHER FATHER

1241 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Greene County Health Office,

County File Number 45-6-50

Date Filed 6-6-45

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, ^{and} E. M. Thaw
Embalmer, Registered Apprentice No. 3687

working under my personal supervision.

Signed [Signature]
Licensed Embalmer No. 503
P. O. Address Republic MD

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

Registration District No. 123

Primary Registration District No. 5455

1. PLACE OF DEATH: Greene
(a) County Greene
(b) City or town Rural Republics Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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

3. (a) PRINT FULL NAME Freda L. Pearce
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July (Month) 1 (Day) 1945 (Year)

8. AGE: Years 32 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) no

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

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

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

19. (a) _____ (Date received local registrar) (b) Florence Britain (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day _____ year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

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

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

16940