

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012050  
STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 24

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bucyrus</u> <u>1070</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Texas Co. Mem. Hosp. Ida. 5hrs</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>15 miles S.W. Bucyrus</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Martin</u> Last <u>Pearcy</u>			4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>11-10-78</u>	9. AGE (In years of birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Scott County, Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James A. Pearcy</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Fulks</u>	14. NAME OF HUSBAND OR WIFE <u>Julia Pearcy</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>486-24-2921</u>	17. INFORMANT <u>Gladys Shelhammer-Houston, Mo</u> Address
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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) <u>Intra-abdominal Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Secondary to Carcinomatosis from</u> DUE TO (c) <u>Primary Carcinoma of Stomach. 151X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic degenerative decompensated heart disease grade IV</u>		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.) <u>Death while watching TV</u>
20c. TIME OF INJURY Hour <u>6:10 p</u> Month <u>6</u> Day <u>15</u> Year <u>1949</u> a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Houston, Mo</u>	COUNTY <u>Texas</u>	STATE <u>Missouri</u>
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21. I attended the deceased from June 15, 1949 to 3/4/59 and last saw <sup>him</sup> alive on 3/4/59  
Death occurred at 6:10 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. J. Burns, MD</u> (Degree or title)	22b. ADDRESS <u>Houston, Mo</u>	22c. DATE SIGNED <u>3/7/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-8-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hickory Ridge</u>	23d. LOCATION (City, town, or county) (State) <u>Texas County, Missouri</u>
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24. FUNERAL DIRECTOR <u>Raymond F. Duff-Houston, Mo.</u>	25. DATE REC'D. BY LOCAL REG. <u>3-31-59</u>	26. REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Frank E. Wood* .....

Licensed Embalmer No. *4026* .....  
P. O. Address..... *Houston* .....

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.