LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

17471

1. PLACE OF DEATH
County St. Louis — Registration District No. 1160 — File No.
Township ~~Central~~ — Primary Registration District No. 4470 — Registered No. 22.
City University (No. 6623 Etzel Ave St. Ward)

2. FULL NAME Malcolm E. Pearson
(a) Residence. No. 6623 Etzel Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12/18 1897

7. AGE — YEARS: 22 — MONTHS: 3 — DAYS: 18 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Insurance
(c) Name of employer: Missouri State Life

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER: William E. Pearson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Boston
(STATE OR COUNTRY) Mass.
12. MAIDEN NAME OF MOTHER: Adelaide Durgin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. L. Lange
(Address) 6623 Etzel Ave

15. FILED 4/8, 1920 John H. Sutter, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 7 1920

17. I HEREBY CERTIFY, That I ~~attended deceased~~ held an inquest from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at not known m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
suicide by inhaling illuminating gas
164A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 168 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) R. B. Denny Coroner M.D.
4-7, 1920 (Address) Creve Coeur Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bethania Cem. — DATE OF BURIAL: 4/10 1920

20. UNDERTAKER: John Koch & Son — ADDRESS: 4650 Easton

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No. ....., ... St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
.....
.....
.....
.....
.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY: .....
(SECONDARY)
.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST, CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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