

APR 21 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County GreeneRegistration District No. 318File No. 11919Township SpringfieldPrimary Registration District No. 2001Registered No. 0220City SpringfieldSt. St. John's HospitalSt. 1 Ward

2. FULL NAME

PEARL RAYMOND DAWSON(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.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

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)

DEC. 20, 1895

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.✓41224

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

FARMER

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

G.V. NICHOLSON

9. BIRTHPLACE (CITY OR TOWN)

ASH GROVE

(STATE OR COUNTRY)

MO

10. NAME OF FATHER

MATTHEW DAWSON

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

STANFORD

(STATE OR COUNTRY)

KY

12. MAIDEN NAME OF MOTHER

JOS. PHINE MCCORMACK

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

STANFORD

(STATE OR COUNTRY)

KY

PARENTS

14.

INFORMANT

(Address)

A. R. DawsonSpringfield, Mo

15.

Date

Mar 15, 1937Chas A George

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

3/141937

17.

I HEREBY CERTIFY, That I attended deceased from 3/1/37, 1937to 3/14, 1937that I last saw h.l.m. alive on 3/13, 1937, and that death occurred, on the date stated above, at 2:47 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
Cerebral Concussion
fractures as follows: Right Rib, mandible,
right sub., seven ribs, right side
 (duration) yrs. mos. da.

CONTRIBUTORY

(SECONDARY)

(duration) yrs. mos. da.

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)

, 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.
Accidental (Car collision)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Ash Grove Mo

Mar 16 1937

20. UNDERTAKER

ADDRESS

Galbraith Funeral Home
Ash Grove Mo

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.

