

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 223

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(c) Name of hospital or institution: Sedalia # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 hours  
In this community life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pettis  
(c) City or town Sedalia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 427 1/2 Patton  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME DOROTHY PEARSON

8. (b) If veteran, name war \_\_\_\_\_ No. \_\_\_\_\_  
8. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race col  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Riley Pearson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 4-29-1915  
(Month) (Day) (Year)

8. AGE: Years 25 Months 2 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Eugene Bentley  
13. Birthplace Sedalia Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Ida Paxton  
15. Birthplace Sedalia Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Paxton  
(b) Address Sedalia Mo

17. (a) Sedalia Mo (b) Date there July 3, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Glenwood Cemetery

18. (a) Signature of funeral director F. D. Ferguson  
(b) Address Sedalia Mo

19. (a) 7/3/40 (b) Mrs. Harry Sneed  
(If received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27  
year 1940 hour 7 1/2 minute 30 P. M.  
21. I hereby certify that I attended the deceased from July 27  
1940 to July 29 1940  
that I last saw him alive on July 30 1940  
and that death occurred on the date and hour stated above.  
Immediate cause of death Pertussis ✓

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?  
90 10  
while at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature M. C. Dancy (M. D. or other) \_\_\_\_\_  
Address Sedalia Mo Date signed 7/3-40

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

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4  
4

124

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 8-9-40

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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *H. D. Ferguson*  
Licensed Embalmer No. *2172*  
P. O. Address *Sedalia, Mo.*

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, above space should be left blank.

Registration District No. **668**

Primary Registration District No. **3032**

Registrar's No. **223**

1. PLACE OF DEATH:  
(a) County **Pettis**  
(b) City or town **Peabolin**  
(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 **Dorothy Pearson**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **col** 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: (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one year
	<b>25</b>	<b>2</b>	<b>1</b>	min.

9. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_

(a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

19. DATE OF DEATH: Month **July** day **27** year **1944** hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis**  
**Victory Gun as a blow in the abdomen**

Due to \_\_\_\_\_  
Due to **N. M. D.**

Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

SUPPLEMENTARY

Part 2

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

WRITE PLAINLY—USE IN FADING BLACK INK—MAKE A PERMANENT RECORD

