

OCT 12 1940

State File No. _____

Registration District No. 124

Primary Registration District No. 4070

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Jackson Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 309 W 1st St. St.
 (If not in hospital or institution, write street number or location) W
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days

8. (a) PRINT FULL NAME John Nicklaus PERSEL

8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Caroline Friedhoff Pearsell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: (Month) May (Day) 28 (Year) 1885

8. AGE: Years 55 Months ✓ Days 23 If less than one day hr. _____ min. _____

9. Birthplace Don't know Mo. 0 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer 6

11. Industry or business _____ 9

MOTHER FATHER { 12. Name John Pearsell 1

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

14. Maiden name Not known

15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. A. Pearsell
 (b) Address 719 Good Hope St. Cape Girardeau, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 1940 (Month) (Day) (Year)
 (c) Place: burial or cremation Buried in Catholic Church

18. (a) Signature of funeral director W. E. Conroy
 (b) Address 421 Longway

19. (a) 9-24-40 (Date received local registrar) (b) D. G. Leibert (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
 (c) City or town Jackson (If outside city or town limits, write "RURAL")
 (d) Street No. 313 W 1st St. (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 21 year 40 hour 8 minute 50 P.M.

21. I hereby certify that I attended the deceased from 9-1-40, 19____, to 9-21-40, 19____; that I last saw him alive on 9-21-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia with terminal coma Duration 2 days

Due to: Practically absent

Due to: _____

Other conditions: Arterio Sclerosis (Include pregnancy within 3 months of death)

Major findings: Of operations _____

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) _____

(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? 120

(While at work) _____ (Specify type of place) (e) Manner of injury _____

23. Signature D. G. Leibert (Date signed 9-24-40)
 Address Jackson

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.

131

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.....

BA Meyer
.....
Licensed Embalmer No. *3057*

P. O. Address *Jackson 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31635

Registration District No.

Primary Registration District No.

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Jackson
(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 John N. Pensek

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

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 day _____ h. _____ 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 _____ (City, town, or county) _____ (State or foreign country)

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

16. (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 21 - 40
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

terminal coma

Due to Prostatic Obstruction

Enlarged Prostate

Other conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____ 137

Of autopsy _____

Duration

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) _____

(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 _____

SUPPLEMENTAL

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

Jackson Mo.

