

FILED APR 9 1942
Registration District No. 843

Primary Registration District No. 6106

Registrar's No. _____

1. PLACE OF DEATH: Stone

(a) County: Stone

(b) City or town: Galena, Mo. Rural
(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 _____
In this community: 63 yrs. Entire Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Amanda C. Pearson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: John Pearson

6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: Nov. 25 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>3</u>	<u>19</u>	hr. min.

9. Birthplace: Stone Co. Mo. 17
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business _____

MOTHER FATHER

12. Name: Louis J. Blair

13. Birthplace: Stone Co. Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name: Sarah Wallen

15. Birthplace: Ark. 1
(City, town, or county) (State or foreign country)

16. (a) Informant: Crystal Morris

(b) Address: Galena, Mo.

17. (a) Burial (b) Date thereof: Mar. 15 - 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Yacum Bonds

18. (a) Signature of funeral director: Elliott J. Cheatham

(b) Address: Galena, Mo.

19. (a) Mar 15/42 (b) Nellie Bromley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Stone 104

(c) City or town: Galena, Mo. Rural
(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: March day: 14
year: 42 hour: 10 minute: 30 P.M.

21. I hereby certify that I attended the deceased from: at Death
_____ 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: Dropsical Condition - Died with out medical attention ✓
Duration: 1 yr.

Due to _____

Due to _____

Other conditions: _____
(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? _____

While at work? _____ (Specify type of place)
(c) Means of injury: _____

23. Signature: Elliott J. Cheatham (M.-D. or other) Coroner

Address: Galena, Mo. Date signed: 3/15/42

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

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RECEIVED

District Health Officer No. 6,

District File Number 442-437

Date Filed APR 8 1942

STATEMENT BY LICENSED EMBALMER

nat

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.....

Errett J. Cheatham

Licensed Embalmer No.....

3879

P. O. Address.....

Errett J. Cheatham

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12232

Registration District No. 843

Primary Registration District No. 6106

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Rural
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Amanda C. Pearson

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

4. Sex F 5. Color or race W 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 Nov 25
(Month) (Day) (Year)

8. AGE: Years 63 Months 3 Days _____
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 1 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him/her alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Respirical Cond,
Due to _____
nephritic condition
Due to _____
also chronic

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 _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-12232 1942