

No. 2  
-1-4-41  
5-17-39  
I X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7721**

**FILED MAR 13 1944**  
Registration District No. **2074**

Primary Registration District No. **4318**

Registrar's No. **30**

**1. PLACE OF DEATH:**

(a) County Mauro

(b) City or town Vienna

(c) Name of hospital or institution 1 -

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether years, months or days)

In this community ✓

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mauro (b) County 63

(c) City or town Vienna (If outside city or town limits, write "RURAL") Mo

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country 1

**3. (a) PRINT FULL NAME** SARAH C PEARSON

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

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Jan. 17, day 1944 hour 5:30 minute AM

**21. I hereby certify that I attended the deceased from** June 4, 1941 to March 1, 1943

**4. (a) Sex** Female **5. Color of hair** White

**6. (a) Single, widowed, married, divorced** Married

**6. (b) Name of husband or wife** Chas Pearson **6. (c) Age of husband or wife if alive** 83 years

**7. Birth date of deceased.** 9 - 16 - 1861  
(Month) (Day) (Year)

that I last saw h. er. alive on March 1, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

**8. AGE:**

Years	Months	Days	If less than one day
<u>82</u>	<u>4</u>	<u>1</u>	<u>✓</u> hr _____ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

**9. Birthplace** Miller Co Mo  
(City, town, or county) (State or foreign country)

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

**10. Usual occupation** Housewife

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

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

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

**12. Name** Woodson Street

**13. Birthplace** unknown 9  
(City, town, or county) (State or foreign country)

**14. Maiden name** Erna Reynolds

**15. Birthplace** unknown 9  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Chas Pearson

**17. (a) Address** Vienna Mo

**17. (a) (Burial, cremation, or removal)** Burial **(b) Date thereof** 1-19-44  
(Month) (Day) (Year)

**18. (a) Signature of funeral director** W. C. Birmingham

**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 0

**23. Signature** S. C. Howard (M. D. or other) \_\_\_\_\_  
Address Vienna, Mo Date signed 2/18/44

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

3  
0  
0

1096

RECEIVED

District Health Officer No. 91

District File Number.....

Date Filed 3-9-44

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 A. C. Bunnings

Licensed Embalmer No. 3664

P. O. Address Verona N.J.

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.