

S. No. 2
M-9-4-41
v. 5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 15 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33741
State File No.

Registration District No. 12 Primary Registration District No. 1800 Registrar's No. 117

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution State Hospital No 2
(d) Length of stay: In hospital or institution 3 yr 8 M. 13 da
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(d) Street No 19 East 29th
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Ada Pearson
(b) If veteran, name war ADA PEARSON
(c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 31
year 1944 hour 9-40 minute a. M.

4. Sex F. 5. Color of race W.
6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Charles E Pearson
6. (c) Age of husband or wife if alive years 7
7. Birth date of deceased May 19 1869

21. I hereby certify that I attended the deceased from 10-29 1944 to 10-31 1944
that I last saw her alive on 10-31 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 5 Days 12
If less than one day hr. min.

Immediate cause of death Hypostatic Pneumonia Bronchial
Due to Bedridden and general debility
Other conditions Small Pox crisis

9. Birthplace Indiana
10. Usual occupation P. Nurse

PHYSICIAN
Major findings: Of operations 107
Of autopsy

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

MOTHER FATHER
11. Industry or business
12. Name John M. Anderson
13. Birthplace Indiana
14. Maiden name Mervia Lamm
15. Birthplace Indiana

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?
(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 C. E. Salter (M. D. or other)
Address St Joseph Mo Date signed

16. (a) Informant Reginal Hospital
(b) Address St Joseph Mo
17. (a) Removal (b) Date thereof 10-31-1944
(c) Place: burial or cremation N C Mo
18. (a) Signature of funeral director Walter Meierhoffer
(b) Address 1007 Zarahoni St Joseph Mo
19. (a) 10-31-44 (b) Registrar's signature

1371

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 E. M. Placet

Licensed Embalmer No. 1848

P. O. Address N. E. 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, fact should be so stated above.