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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 11 1944
Registration District No. 1244

Primary Registration District No. 4201

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Republic
(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) 7
(d) Length of stay: In hospital or institution..... (Specify whether
In this community 50 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Republic (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 Alice Samantha Pearce

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Joseph C. Pearce 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased Apr. 29, 1873 (Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 2 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER
12. Name William T. King
13. Birthplace N. Carolina (City, town, or county) (State or foreign country)
14. Maiden name Nancy Suley
15. Birthplace N. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Miss Cleo Pearce
(b) Address Republic, Mo.

17. (a) Burial (b) Date thereof Dec. 4, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evergreen Cemetery

18. (a) Signature of funeral director R. E. Chumantud Co.
(b) Address Republic, Mo.

19. (a) Dec. 4, 1944 (b) Florence Britain
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1
year 1944 hour 6:30 minute 7 P. M.

21. I hereby certify that I attended the deceased from June 1, 1944 to Dec 1, 1944

that I last saw him alive on Dec 1, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 Days

Due to Hypertension

Due to

Other conditions Senility 830
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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 E. L. Beal M.D. (M. D. or other).....

Address Republic, Mo. Date signed 12/2/44

1241

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Greene County Health Office,

County File Number 44-12-84

Date Filed 12/8/44

FEB 16 1945

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

S. M. Thurmon

Registered Apprentice No. 3687

working under my personal supervision.

Signed

R. E. Thurmon

Licensed Embalmer No. 5023

P. O. Address Republic 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.