

FILED JUL 8 1946Registration District No. **776**Primary Registration District No. **3020**Registrar's No. **66****1. PLACE OF DEATH:**

(a) County **Franklin**
 (b) City or town **Washington**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 days**
 (Specify whether
 In this community **5 years**
 years, months or days)

3. (a) PRINT FULL NAME James Robert Pearson.

3. (b) If veteran, name war No. **None.**
3. (c) Social Security No. **None.**

4. Sex **Male 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married****
6. (b) Name of ~~husband's~~ wife **Nell Pearson 6. (c) Age of ~~husband's~~ wife if alive **27** years**
7. Birth date of deceased **September 10th, 1914**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
31 9 2 hr. min.

9. Birthplace **St. Charles Missouri.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Dentist.**

11. Industry or business

12. Name **J. R. Pearson,**
13. Birthplace **Chariton County, Missouri.**
 (City, town, or county) (State or foreign country)
14. Maiden name **Margaret Ellen Emmons,**
15. Birthplace **St. Charles, Missouri.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nell Pearson**
(b) Address **410 W. 3rd St. Washington, Mo.**
17. (a) **Burial (b) Date thereof **June 14, 1946****
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington, Mo.**
18. (a) Signature of funeral director **Reibung & Vitt, Inc.**

(b) Address **Washington, Mo.**
19. (a) **6/15/46 (b) **[Signature]****
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**
 (c) City or town **Washington**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **410 W. 3rd St.**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June day **12th**, year **1946** hour **6:00** minute **35 A.M.****
21. I hereby certify that I attended the deceased from **June 8, 1946**
 19 to **June 12** 1946
 that I last saw him alive on **June 12** 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Acute ~~urinary~~ nephritis **2 days**
Acute intestinal obstruction **2 days**
 Due to **internal injuries**
due to auto accident

Other conditions **Fracture of pelvis**
 (Include pregnancy within 3 months of death)

Major findings: **ADDITIONAL**
 Of operations **SUPPLEMENTARY**
INFORMATION
 Of autopsy **REQUESTED**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **Accident**
 (b) Date of occurrence **6-8-46**
 (c) Where did injury occur? **Warrenton Warren Mo**
 (City or town) (County) (State)
Public Highway U.S. 46
 (Specify type of place)
 (d) Did injury occur in or about home or farm, in industrial place, in public place?
 While at work? **Auto accident**
 (Specify type of place) (b) Means of injury
Herbert H. Schmidt, M.D.
Schroeder Bldg, Washington, Mo.
 23. Signature **Herbert H. Schmidt, M.D.**
 Address **Schroeder Bldg, Washington, Mo.** Date signed **6-13-46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 7-3-46

JUL 10 1946

AUG 1 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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Lester H. Witt
Licensed Embalmer No. 3254
P. O. Address Washington, 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.

July 66

Registration District No. *116*

Primary Registration District No. *3020*

Registrar's No. *66*

1. PLACE OF DEATH:
(a) County *Franklin*
(b) City or town *Washington*
(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 *James R. Pearson*
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 *M*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: *Sept 10*
(Month) (Day) (Year)

8. AGE: Years *31* Months _____ Days _____ (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* 2
year *1966* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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: *Shock & internal injuries - fractured pelvis*

Due to: *Auto accident - Car was crowded off highway by another car and turned over.*

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

Major findings: _____ Of operations _____

Of autopsy: *1966 7 29*

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) *Auto accident.*

(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) Means of injury _____

23. Signature: *Hubert H. Schumacher* (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

18794

AUG 1 1945

19920