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

FILED AUG 8 1949

STANDARD CERTIFICATE OF DEATH

State File No. 22478

BIRTH NO. 61861-48 REG. DIST. NO. 13 PRIMARY REG. DIST. NO. 3003 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lancaster	
b. CITY (If outside corporate limits, give RURAL and give township) Monett		c. CITY (If outside corporate limits, give RURAL and give township) Stotts City	
c. LENGTH OF STAY (In this place) 3 days		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Vincent Hosp			
3. NAME OF DECEASED (Type or Print) Beverly Ann Pearcey		4. DATE OF DEATH (Month) (Day) (Year) June - 29 1949	
a. (First)	b. (Middle)	c. (Last)	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Oct - 27 - 1948
9. AGE (In years last birthday) 8		IF UNDER 1 YEAR Months 2	IF UNDER 12 HRS. Hours 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Monett, Mo.
			12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Roy M. Pearcey	13b. MOTHER'S MAIDEN NAME Nell Rose Harrow	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Roy M. Pearcey	ADDRESS Stotts City, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Typhoid fever		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		040X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 26, 1949**, to **June 29, 1949**, that I last saw the deceased alive on **June 29, 1949**, and that death occurred at **11:45 a.m.** from the causes and on the date stated above.

23a. SIGNATURE Robert D. Doolley M.D.	(Degree or title)	23b. ADDRESS Monett Mo	23c. DATE SIGNED July 23 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 1 - 1949	24c. NAME OF CEMETERY OR CREMATORY Moore Cemetery	24d. LOCATION (City, town, or county) (State) Stotts City, Mo
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DATE REC'D BY LOCAL REG. 7-23-49	REGISTRAR'S SIGNATURE W. M. West	12	25. FUNERAL DIRECTOR'S SIGNATURE May L. Truett	ADDRESS W. Vernon Mo.
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RECEIVED JUL 28 1949

District Health Office No. 6,

District File Number 749-846

Date Filed 7-28-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Max L. Russell

Licensed Embalmer No. 4252

P. O. Address Wilmington, 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.