

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34088

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 165

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location) N. Tom St. Rd. 0492	

3. NAME OF DECEASED (Type or Print) a. (First) ANNIE b. (Middle) E c. (Last) PEARCE			4. DATE OF DEATH (Month) (Day) (Year) 10-22-51		
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Aug 25-1877	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 48 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lynn Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS D. Pearce Sycamore 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 11 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES *Mention conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension and arteriosclerosis DUE TO (c) Parkinson's disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		years.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 33ix	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 10-18, 1951, to 10-22, 1951, that I last saw the deceased alive on 10-22, 1951, and that death occurred at 1 PM, from the causes and on the date stated above.

23a. SIGNATURE Robert M. Ferguson Mo (Degree or title)	23b. ADDRESS Webb City	23c. DATE SIGNED 10/24/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-24-51	24c. NAME OF CEMETERY OR CREMATORY Harney Cem	24d. LOCATION (City, town, or county) (State) La Russell Mo
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DATE REC'D BY LOCAL REG. Oct 24 51	REGISTRAR'S SIGNATURE D.L. Hutchins	FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jackson Sons, Sycamore Mo
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED 10-20-51  
Jasper County Health Office  
County File Number 51/10/81  
Date Filed 10-21-51

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 me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Wm K Jackson

Licensed Embalmer No. 3954

P. O. Address Lawrence 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.