

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3429

STATE FILE NUMBER

FILED JAN 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

616

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                               |   |   |   |  |  |
|---|-------------------------------|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |                               | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>St. Louis</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                         |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>  |                               | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location) <b>2270 2207 Walnut</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Zellner</b> Middle Last <b>Pearson</b>  |                               |   | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>15</b> Year <b>58</b>   |   |  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>5-5-1904</b>  | 9. AGE (In years last birthday) <b>53</b>                                 | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>   | 11. BIRTHPLACE (City and state or country) <b>Cannon Miss.</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |
| 13a. FATHER'S NAME <b>John Allen</b>  |                               | 13b. MOTHER'S MAIDEN NAME <b>Fannie Grant</b>   |   | 14. NAME OF HUSBAND OR WIFE <b>Hardest Pearson</b>                        |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>  |                               | 16. SOCIAL SECURITY NO. <b>Unk.</b>   | 17. INFORMANT Address <b>Mable Hall 2703 aWalnut St.</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>   |                               |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <b>Undet</b>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |                               |   |   |   | 331x   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pal. Congestion</b>  |                               |   |   |   | 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                               |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)                                |   |  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |                               |   |   |   |  |  |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  | 20f. CITY, TOWN, OR LOCATION  |   | COUNTY STATE   |  |
| 21. I attended the deceased from <b>1-7-58</b> , to <b>1-15-58</b> and last saw her <sup>xxx</sup> alive on <b>1-15-58</b><br>Death occurred at <b>3:29</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                               |   |   |   |  |  |
| 22a. SIGNATURE <b>S. G. Trase</b> (Degree or title) <b>, M.D.</b>   |                               |   | 22b. ADDRESS <b>2601 Whittier Street</b>  |   | 22c. DATE SIGNED <b>1-16-58</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  | 23b. DATE <b>1-20-58</b>      | 23c. NAME OF CEMETERY OR CREMATORY <b>Washington park</b>   |   | 23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b> |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>J. McClendon 4535 Washington Blvd.</b>  |                               |   | 25. DATE RECD. BY LOCAL REG. <b>JAN 17 '58</b>  | 26. REGISTRAR'S SIGNATURE <b>Carl Smith No 228B</b>                       |  |  |

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 .....  
Signature of Student Embalmer

Signed *John R. Cunningham* .....

Licensed Embalmer No. *4476* .....

P. O. Address *4700 N. Hamm* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.