

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004972
STATE FILE NUMBER

FILED MAR 3 1959 Registration District No. 93 Primary Registration District No. Registrar's No. 59-19

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Dade				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Dade					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lockwood TWP		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Lockwood Mo		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lin Lockwood Mo			Length of stay in lb yrs		d. STREET ADDRESS (If outside, give location) 1 mi. n Lockwood		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Richard Middle Walter Last Pearson				4. DATE OF DEATH Month Feb. Day 21 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1884		9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 6 Days 20	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Dade Co Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Fred Pearson			13b. MOTHER'S MAIDEN NAME Virginia Lack Pearson			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Carrie Gillman Lockwood Mo				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)							
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 4201						
20c. TIME OF INJURY Hour Month, Day, Year 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 3-54 to and last saw ^{him} alive on April 58 Death occurred at 10:00p on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Max Heilbrunn M.D.			22b. ADDRESS Lockwood Mo			22c. DATE SIGNED 2/22/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 24 1959	23c. NAME OF CEMETERY OR CREMATORY Lockwood			23d. LOCATION (City, town, or county) (State) Lockwood Mo			
24. FUNERAL DIRECTOR W.R. Allison Greenfield Mo.			25. DATE RECD. BY LOCAL REG. 2/26/1959		26. REGISTRAR'S SIGNATURE J.C. Canada				

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MAX HEILBRUNN, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *W.R. Allison*

Licensed Embalmer No. *4404*

P. O. Address *Greenfield*

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.