

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-038156

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 272

AMENDED

FILED NOV 15 1961

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in lb <u>20 Hrs.</u>		c. CITY OR TOWN <u>R.R. 1 St. Charles</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Josephs Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.R.1 St. Charles Mo.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Pearson</u> Last <u>Pearson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6.</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/1872</u>		9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		IF UNDER 24 HR Hours <u>    </u> Min. <u>    </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>John D. Reid</u>				13b. MOTHER'S MAIDEN NAME <u>Turzah Hill</u>				14. NAME OF HUSBAND OR WIFE <u>The Late Charles Pearson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Reginald Pearson Rt. 1 St. Chas. Mo</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Phenomenia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Dehydration</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>few months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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.)									
20c. TIME OF INJURY Hour <u>    </u> a.m. <u>    </u> p.m. Month, Day, Year <u>    </u>													
20d. INJURY OCCURRED WHILE AT WORK <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 <u>11/5/61</u> to <u>11/6/61</u> and last saw her alive on <u>11/6/61</u> Death occurred at <u>11/6/61 10 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>O.K. Shui M.D.</u>						22b. ADDRESS <u>840 N. Main - St. Charles Mo</u>			22c. DATE SIGNED <u>11/7/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Barbers Cemeterys</u>		23d. LOCATION (City, town, or county) <u>Rockwood Illinois</u>		23e. (State)					
24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 7-61</u>		26. REGISTRAR'S SIGNATURE <u>Marellle Wilson</u>							

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

NOV 16 1961

**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

*Sheldon Collier*

Licensed Embalmer No.

*3382*

P. O. Address

*St. Ann 7*

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.