

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

32822

**1. PLACE OF DEATH**

County Wayne Registration District No. 89-3 File No. \_\_\_\_\_  
 Township Black River Primary Registration District No. 6189 Registered No. 17  
 City \_\_\_\_\_ (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Pearl Nelson

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (If nonresident give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 3 1/2 yrs. mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? yrs. mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** M  
 (write the word)  
**5A. IF MARRIED, WIDOWED, OR DIVORCED**  
 HUSBAND OR (OR) WIFE OF Carl Nelson  
**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) 27 Aug. 1895  
**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hr. or \_\_\_\_\_ min.  
34 22  
**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE** (CITY OR TOWN) Wayne County  
 (STATE OR COUNTRY) Mo.  
**10. NAME OF FATHER** Thomas Page  
**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) Illinois  
 (STATE OR COUNTRY) \_\_\_\_\_  
**12. MAIDEN NAME OF MOTHER** Mary Gilbreath  
**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN) Illinois  
 (STATE OR COUNTRY) \_\_\_\_\_

**14. INFORMANT** Carl Nelson  
 (Address) Fasket, Mo.  
**15. FILED** Sept 19 1929 Mrs. Hattie McShu  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) 9-18-1929  
**17.** I HEREBY CERTIFY, That I attended deceased from February 1927, to 9-18-, 1929  
 that I last saw him alive on August 1929, and that death occurred, on the date stated above, at 6 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Tuberculosis

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 (duration) 2 yrs. 6 mos. \_\_\_\_\_ ds.  
**CONTRIBUTORY (SECONDARY)** 31  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
**19. DID AN OPERATION PRECEDE DEATH?** No DATE OF \_\_\_\_\_  
**20. WAS THERE AN AUTOPSY?** No  
**WHAT TEST CONFIRMED DIAGNOSIS?** \_\_\_\_\_  
 (Signed) Geo F. Wagner, M. D.  
9-18, 1929 (Address) Greenwell, Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Reeker Cemetery **DATE OF BURIAL** 9-19-1929  
**20. UNDERTAKER** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

N. B. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important. Property classified. 1929-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00

OCT 24 1929

235

1  
2

DATA BASES & LAJIC...  
... ..

... ..  
... ..

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Wayne  
Township Black River  
City Pearl (No. 17)

Registration District No. 892  
Primary Registration District No. 6194

File No. \_\_\_\_\_  
Registered No. 17  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

Pearl Nelson

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

**PARENTS**  
10. NAME OF FATHER \_\_\_\_\_  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_  
12. MAIDEN NAME OF MOTHER \_\_\_\_\_  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT \_\_\_\_\_  
(Address) \_\_\_\_\_

15. FILED Oct. 2, 1929 Mrs. Hattie McPherson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19\_\_\_\_ (Address) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER Had no undertaker ADDRESS \_\_\_\_\_

**SUPPLEMENTARY**

IS A PERMANENT RECORD

Every item of information should be carefully supplied. Items should be stated EXACTLY. PHYSICIANS should state N. B. OF DEATH is a very serious matter, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH is a very serious matter, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRAR RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S. 3282A