JUN 26 1929

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

Do not use this space.

18610

1. PLACE OF DEATH

County: Laclede. Registration District No.: 449 File No.:

Township: Lebanon Primary Registration District No.: 5609 Registered No.: 15544

City: ~~Lebanon~~ (No. ..., ... St. ..... Ward)

2. FULL NAME Lavona May Pierce

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 10 1928

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	4	26	

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) Springfield Mo.

PARENTS

10. NAME OF FATHER W. H. Pierce

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ramey Neb.

12. MAIDEN NAME OF MOTHER Cecil Browning

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ramey Neb.

14. INFORMANT W. H. Pierce
(Address) Lebanon Mo.

15. FILED 7/6 1929 J. M. Billing REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 6 1929

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 6 1929, that I last saw him alive on May 6 1929, and that death occurred, on the date stated above, at 6:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture Skull
Accident by falling from Chair
15 GH
1 HB
(duration) yrs. 1 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no. DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) J. A. Hamilton, M. D.
, 19 (Address) Lebanon, 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	DATE OF BURIAL
Lebanon Cemet	5/7 1929
20. UNDERTAKER	**ADDRESS**
Palmer	Lebanon Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.