

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

Do not use this space.

35582

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.* (No.)

Sanitarium

File No.

Registered No. **10352**

St. Ward)

2. FULL NAME

Pierce Powers

(a) Residence. No. *1715 O'Fallon* St., *13* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *57* yrs. *3* mos. *13* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

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

July 8, 1872

7. AGE

YEARS

57

MONTHS

3

DAYS

12

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Candy Salesman*

(b) General nature of industry, business, or establishment in which employed (or employer) *Unknown*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

John Powers

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

"

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

Louis H. Stahl

(Address)

5300 Annapolis

15.

FILED

22 1929 May @ St. Louis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/20/29* 19

17.

I HEREBY CERTIFY, That I attended deceased from

4/30/28, 19... to *10/20/29*, 19... that I last saw h... alive on *10/12/29*, 19... and that death occurred, on the date stated above, at *12* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epilepsy

178 97

(duration) *1* yrs. *5* mos. *21* ds.

CONTRIBUTORY (SECONDARY) *Arteriosclerosis*

(duration) *1* yrs. *5* mos. *21* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical

(Signed) *Louis H. Stahl*, M. D.

10/20/29 19 (Address) *5300 Annapolis*

*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

Calvary Cemetery Oct 23 1929

20. UNDERTAKER

ADDRESS

Callahan Bros 1102 Grand St

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.

