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.

SEP 6 1939

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

28330
Do not use this space.

1. PLACE OF DEATH
(a) County JACKSON — Registration District No. 399
(b) Township KAW — Primary Registration District No. 1002 — Registered No. 3332
(c) City KANSAS CITY — (d) Street No. RESEARCH HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 626 MR. BURTON J. PIERCE
(a) Residence, No. 5829-OAK St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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~~ MRS. MOLLIE B PIERCE
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JANUARY 28-1874
7. AGE: YEARS 65 — MONTHS 6 — DAYS 25 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. SALESMAN K.C. FUEL OIL CO.
9. Industry or business in which work was done, as saw mill, bank, etc. CONSTABLE HURD PRINTING CO.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) HASTINGS NEBRASKA

FATHER
13. NAME GUSTAVIO D. PIERCE
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

MOTHER
15. MAIDEN NAME UNKNOWN
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) MRS. MOLLIE B. PIERCE 5829-OAK STREET
18. BURIAL, CREMATION, OR REMOVAL PLACE MT. MORIAH DATE AUGUST-24, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. W. NEWCOMER'S SONS 1401-BRUSH CREEK BLVD
20. FILED 8/23, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) AUGUST-22, 1939
22. I HEREBY CERTIFY, That I attended deceased from 8/19, 1939, to 8/22, 1939
I last saw him alive on 8/22, 1939. Death is said to have occurred on the date stated above, at 2:30 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	
Diabetes 59	
Other contributory causes of importance: Diabetic Coma	8/18/39
Coronary occlusion	

Name of operation Mayo Date of
What test confirmed diagnosis? Laboratory Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Henry Raab M. D.
(Address) 414 Wurthman Bldg KC Mo

(Licensed Embalmer's Statement on Reverse Side)

12:30. 2

MAY 5 1948

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed E. M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. C. Mo.

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 this body is not embalmed, above space should be left blank.