

SEP 6 1939

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

28381
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Kansas City, Mo. (d) Street No. 331 West Gregory 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

620 Mrs. Christina E. Pierce
 (a) Residence, No. 331 West Gregory Blvd 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Guy Pierce
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 7, 1866
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
72 9 18
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 25, 1939
 I HEREBY CERTIFY, That I attended deceased from Aug 21 1939, to Aug 25, 1939.
 I last saw her alive on Aug 25, 1939. Death is said to have occurred on the date stated above, at 12:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Coronary Occlusion
Several wks before I was called.
 Date of onset 940
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis Clinical Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ 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 W.P. Jones M.D.
 (Signed) _____ (Address) 4711 Central Kc Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denmark 7
 13. NAME Maria Lorenza 6
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 1
 15. MAIDEN NAME Don't Know
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
 17. INFORMANT (ADDRESS) Mrs. Gladys Crum
331 West Gregory Blvd.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Aug. 28 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. V. Lindsey & Son
3811 Broadway
 20. FILED 8/28 1939 M. M. Crome
 Local Registrar

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.

Am. W. P. Stevens
Plaza Park Bldg
Rd - Route 5,
Mon. 9:30 to 5.

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.....

..... *Ralph E Miller* Registered Apprentice No. *164*
working under my personal supervision.

Signed *James Wheeler*
Licensed Embalmer No. *3738*
P. O. Address *J.C. Miller*

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.