

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.

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

**40203**  
 Do not use this space.

1. PLACE OF DEATH 2

(a) County Monroe Co Registration District No. 533

(b) Township Roundaway Primary Registration District No. 5721 Registered No. 104

(c) City Clamer Rd (d) Street No. \_\_\_\_\_ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Isaac T. Pierce

(a) Residence, No. Clamer Rd Mo St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

**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  Della Pierce 1869

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 27 1869

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

79      6      17

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. Retired Farmer

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) Marion Co Mo

FATHER 13. NAME John C. Pierce

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co Mo

MOTHER 15. MAIDEN NAME Pauline Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co Mo

17. INFORMANT (ADDRESS) Mr Isaac H Pierce

18. BURIAL, CREMATION, OR REMOVAL PLACE Bethel Cemetery DATE 11/14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) William H. Barber  
Warrens, Mo.

20. FILED 1217 1939 Isaac H. Newkirk  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 13 1939

22. I HEREBY CERTIFY, That I attended deceased from July 20 1939 to Nov 2 1939

If last saw him alive on Nov 2 1939 Death is said to have occurred on the date stated above, at 7 A m.

The principal cause of death and related causes of importance were as follows:

Chronic Interstitial Nephritis Date of onset 7/20/39

Other contributory causes of importance: 121  
Uremia  
Cerebral apoplexy

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? 3

If so, specify \_\_\_\_\_ (Signed) Dr. B. L. Edrington D.D. M.D. (Address) \_\_\_\_\_

RECEIVED

District Health Officer No. 10

District File Number D-39-2135

Date Filed DEC 9 1939

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 Marion E. Dickey

Licensed Embalmer No. 3957

P. O. Address Shelburne, Vt.

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.