

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11868

State File No. \_\_\_\_\_

Registration District No. 609

Primary Registration District No. 5809

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Rural Newton Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days 1022

3. (a) PRINTED FULL NAME Florence Hoyt Pierce

3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Clorence Pierce  
6. (c) Age of husband or wife if \_\_\_\_\_ years

7. Birth date of deceased June 15, 1866  
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 22  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Frank Pierce  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Frank Sprinkle  
(b) Address Newsho Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-40  
(Month) (Day) (Year)

(c) Place: burial or cremation Oakwood Cemetery

18. (a) Signature of funeral director Charles Wilkerson  
(b) Address Boonville Mo

19. (a) 3-16-40 (Date received local registrar)  
(b) Unat. R. Sale mil. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Newton  
(c) City or town Newsho Mo RR 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th  
year 1940 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb 8 - 1940  
\_\_\_\_\_ 19 \_\_\_\_\_ to Mar 9 1940  
that I last saw him alive on Mar 6 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Chronic nephritis +  
Due to hypertension  
Emphysema  
Due to influenza  
Other conditions influenza  
(Include pregnancy within 3 months of death)

Duration

15  
years

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
543  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature W. L. Lenson (M. D. or other) \_\_\_\_\_  
Address Newsho Mo Date signed 3-16-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

73

RECEIVED

District Health Officer No. 6,

District File Number 440-1118

Date Filed APR 12 1940

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**