DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19733 ~~17436~~

Registration District No. 121 Primary Registration District No. 3009 Registrar's No. 198

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

1. PLACE OF DEATH:

(a) County: Cape

(b) City or town: Cape Girardeau, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community: 10 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Cape

(c) City or town: Cape Girardeau, (If outside city or town limits, write "RURAL")

(d) Street No.: 919 South Fountain St. (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Emmett A. 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: Single

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: Dec. 11, 1939 (Month) (Day) (Year)

8. AGE: Years 1 Months 5 Days 9 If less than one day ..... hr. ..... min.

9. Birthplace: Dewitt Ark. (City, town, or county) / (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER

12. Name: Emmett M. Pierce

13. Birthplace: Ida Ark. (City, town, or county) / (State or foreign country)

MOTHER

14. Maiden name: Louise Johnson

15. Birthplace: Little Rock, Ark. (City, town, or county) / (State or foreign country)

16. (a) Informant: Emmett M. Pierce

(b) Address: Cape Girardeau, Mo.

17. (a) Burrial (Burial, cremation, or removal) (b) Date thereof: 5-21-1941 (Month) (Day) (Year)

(c) Place: burial or cremation: Fairmont Cemt.

18. (a) Signature of funeral director: L. L. Haman

(b) Address: Cape Girardeau, Mo.

19. (a) 5-21-41 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20th year 1941 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from 5/20/41, 19..., to 5/20, 1941; that I last saw him alive on May 20 - 1941, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Encephalitis — Duration: 3 days

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations .....

Of autopsy: Marked Congestion and Edema of brain with inflammatory changes

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature: J. H. Cochran (M. D. or other) D

Address: Cape Girardeau Mo Date signed: 5/21/41

(Licensed Embalmer's Statement on Reverse Side)

80 A

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 L. L. Hanson

Licensed Embalmer No. 2863

P. O. Address Cape Girardeau

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, fact should be so stated above.

o. 2B
-25-41
X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19733

Registration District No. 125 Primary Registration District No. 3029 Registrar's No.

1. PLACE OF DEATH:

(a) County Cape G.

(b) City or town Cape Girardeau
(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 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Emmett A. Pierce

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
1	5	9	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Encephalitis (not able to classify)	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Marked Congestion and Edema of Brain with Inflamatory Changes	
Of autopsy	

PHYSICIAN Underline the cause to which death should be charged statistically.

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature J H Cochran (M. D. or other) MD
Address Cape Girardeau Mo Date signed 7/18/41

19733