

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18373
Registrar's No. 262

FILED JUN 12 1944
Registration District No. 1900

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

(a) County Jasper

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

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

(d) Length of stay: In hospital or institution St. Johns Hospital
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Webb City
(If outside city or town limits, write "RURAL") 6

(d) Street No. 130 North Liberty
(If rural, give location)

(e) Citizen of foreign country? No. 2
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Frank V. Pierce

3. (b) If veteran, name war Spanish-American No. 499-09-8284

3. (c) Social Security No. _____

4. Sex Male 5. Color or race W.

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

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

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

7. Birth date of deceased April 30 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 -- 19 _____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business Jewel Tea Company

MOTHER FATHER {

12. Name John Pierce

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

14. Maiden name no data

15. Birthplace no data
(City, town, or county) (State or foreign country)

16. (a) Informant Widow: Etta Pierce

(b) Address Webb City, Mo.

17. (a) Burial (b) Date thereof 5/22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Hope Cemetery

18. (a) Signature of funeral director Hedge-Nelson

(b) Address Webb City, Mo.

19. (a) 5-20-44 (b) G. Ernest Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19
year 1944 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from 6/11/43, 19____ to 5/19/44, 19____; that I last saw him alive on 5/19/44, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to Chronic interstitial nephritis

Other conditions 13/a
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration _____

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? _____

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

23. Signature E Ernest Johnson (M.D. or other) MD

Address 617 Frank Date signed 5/20/44

44-5-423

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. Sedgwick*

Licensed Embalmer No. *2859*

P. O. Address *Woburn, Mass*

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.