

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 6 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28932

State File No. _____

Registration District No. 537

Primary Registration District No. 112227

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Shelbina
(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 years, months or days)

In this community 2 Weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Cook **999**

(c) City or town Chicago
(If outside city or town limits, write "RURAL") **0**

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Walter W. Pierson

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 Married

6. (b) Name of husband or wife Nell Pierson 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March 22nd 1891
(Month) (Day) (Year)

8. AGE: Years 53 Months 4 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Book Keeper

11. Industry or business _____

MOTHER FATHER { 12. Name Ira Pierson

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

14. Maiden name Sadie Cavanaugh

15. Birthplace Ohio /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nell Pierson

(b) Address Chicago, Ill

17. (a) Burial (b) Date thereof 8/10/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spencer Chapel, Millers Grove, Shelby Mo

18. (a) Signature of funeral director Shelbina Mo

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th
year 1944 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____,

and that death occurred on the date and hour stated above.

Immediate cause of death Was called after man had been dead probably 4 hrs. I last saw him alive 4 yrs ago.

Due to _____

Due to _____

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

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? _____

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

23. Signature D. M. Hood (M. D. or other) _____

Address Shelbina Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

2000

1095 (Licensed Embalmer's Statement on Reverse Side)

8-16-44

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

92
-44

SEP 6 1944

RECEIVED

District Health Officer No.

District File Number 9-44-14

Date Filed SEP 5 1944

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

Body Not Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed *Henry G. Bartelend*

Licensed Embalmer No. *3835*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept.
94

Registration District No.

387

Primary Registration District No.

4499

Registrar's No.

94

1. PLACE OF DEATH

(a) County *Shelby*
(b) City or town *Shelbina*
(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 *2 wk* years, months or days)

3. (a) PRINT FULL NAME *Walter W. Pierson*

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

4. Sex *m* 5. Color of race *w* 6. (a) Single, widowed, married, divorced *m*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive *58* years

7. Birth date of deceased *Mar. 22 1899*
(Month) (Day) (Year)

8. AGE: Years *52* Months *4* Days *12* If less than one day, _____ min.

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

10. Usual occupation *Bookkeeper*

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Sept 11 1944* (b) *Madge Good*
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug* Day *15*
Year *1944* Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

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?

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

28932