S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

100911

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 28 1946

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 4296

Registration District No. 349 Primary Registration District No. 6185 Registrar's No. 6

**1. PLACE OF DEATH:**

(a) County Sullivan
(b) City or town Union 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 —
(Specify whether
In this community Life
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Sullivan 105
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Union Twp. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country —

3. (a) PRINT FULL NAME Vance Everett Pierce

3. (b) If veteran, name war —

3. (c) Social Security No. 545-18-5699

4. Sex M. 0

5. Color or race W

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 Aug (Month) 2 (Day) 1915 (Year)

8. AGE: Years 30 Months 4 Days 18 If less than one day ___ hr. ___ min.

9. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Pipe Welder

11. Industry or business

FATHER
12. Name F. D. Pierce
13. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Flora Jacobs
15. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant F. D. Pierce
(b) Address Elgin Hotel

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof K C-12-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation Fairview Cem.

18. (a) Signature of funeral director Glenn E. Kent & Son
(b) Address Green City Mo.

19. (a) Jan. 2nd 46 (Date received local registrar) (b) Laura M. Shaw (Registrar's signature) Deputy

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 20th year 1945 hour 12:30 minute A. 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.

Immediate cause of death self inflicted gunshot wound into brain

Due to

Due to

Other conditions
(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) suicide
(b) Date of occurrence Dec 20th 1945
(c) Where did injury occur? near Sticklerville Sullivan Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on a farm while hiding from sheriff (Specify type of place)
While at work? no (e) Means of injury Gun

23. Signature G. A. Dale (M.D. or other) D.O.
Address Newtown Mo Date signed 24/12

519 (Licensed Embalmer's Statement on Reverse Side) Sullivan County Coroner

MAR 22 1946

SEP 20 1949

RECEIVED
District Health Officer No. 10
District File Number 1-46-161
Date Filed JAN 24 1946

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, Mo

**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.**