

**FILED MAR 12 1946** STANDARD CERTIFICATE OF DEATH

State File No. **6930**  
Registrar's No. **60**

Registration District No. **316** Primary Registration District No. **6075**

**1. PLACE OF DEATH:**  
(a) County St. Francois  
(b) City or town Farmington, RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri/State-Hospital No. 4 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 2 yrs. 10 mos. 15  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County St. Charles  
(c) City or town St. Charles  
(If outside city or town limits, write "RURAL")  
(d) Street No. 901 South Third  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** AMALIA MARIA TRANGOTT (MOLLIE) PIERCE  
(b) If veteran, name war No  
(c) Social Security No. None

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month February day 5,  
year 1946 hour 5 minute 00 P. M.

4. Sex Female 5. Color or race W.  
6. (b) Name of husband or wife Noah H. Pierce  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband or wife if alive Age Unk. years  
7. Birth date of deceased March 21, 1877  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 13, 1943 1943 to February 5, 1946 1946  
that I last saw her alive on February 5, 1946 1946  
and that death occurred on the date and hour stated above.  
Immediate cause of death Apoplegia  
Duration 3 wks

**8. AGE:** Years 72 Months 10 Days 14  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Psychosis with Central Nervous System  
(Include pregnancy within 3 months of death)

9. Birthplace St. Charles, Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy No autopsy.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name Friedrick Wm. Johannpeter  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Johanna Graewe  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Records State Hospital No. 4  
(b) Address Farmington, Missouri  
17. (a) Burial (b) Date thereof 2-8-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Grove Cem., St. Charles, Mo.  
18. (a) Signature of funeral director Hackmann-Baue Funeral Home  
(b) Address 326 No. Sixth St., St. Charles, Mo.  
19. (a) Feb. 12, 1946 (b) Etther Rudloff  
(Date received local registrar) (Registrar's signature)

23. Signature Ernest L. Stoen (M. D. or other) \_\_\_\_\_  
Address Farmington Date signed 2/6/46

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

5881

RECEIVED

District Health Officer No. 4

District File Number 346-1851

Date Filed 3-11-46

MAR 22 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 Paul K. Dugal

Licensed Embalmer No. 4170

P. O. Address Farmington 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.