S. No. 2
M—5-43
. 5-17-39
› I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 6 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18787

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4707

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4924 St. Louis avenue /
(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 Missouri (b) County 0-26
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4924 St. Louis ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Maude J. Pierce
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex female /
5. Color or race white
6. (a) Single, widowed, married, divorced married /
6. (b) Name of husband or wife Dr. Charles F.A. Pierce
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased June (Month) 19 (Day) 1878 (Year)

8. AGE: Years 67 Months 11 Days 5 If less than one day hr. min.
9. Birthplace New Albany (City, town, or county) Indiana (State or foreign country) /
10. Usual occupation at home
11. Industry or business at home

FATHER
12. Name Moses L. Jackson
13. Birthplace Leavenworth (City, town, or county) Kentucky (State or foreign country) /

MOTHER
14. Maiden name Belle Parrish
15. Birthplace Mead County (City, town, or county) Kentucky (State or foreign country) /

16. (a) Informant Dr. Charles F.A. Pierce
(b) Address 4924 St. Louis avenue
17. (a) burial (Burial, cremation, or removal) (b) Date thereof May- 27- 46 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery, East St. Louis, Ill
18. (a) Signature of funeral director A. Kron F.D. Co.
(b) Address 2707 N. Grand Blv'd
19. (a) MAY 27 1946 (Date received local registrar) (b) J. F. Breeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mayn day 24
year 1946 hour 8 minute 05 p M.
21. I hereby certify that I attended the deceased from Nov 15th, 1945 to May 24th, 1946
that I last saw her alive on May 24th, 1946
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Cerebral hemorrhage 4 days
Due to Arterio-sclerosis ?
Due to
Other conditions (Include pregnancy within 3 months of death) Mitral regurgitation ?

PHYSICIAN

Major findings:
Of operations None made
Of autopsy None made

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 Joseph Davis M.D. (M. D. or Other)
Address 4616 Hancock Blvd Date signed 5-25-46

(Licensed Embalmer's Statement on Reverse Side)

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 Stanley A. Dixon

Licensed Embalmer No. 4693

P. O. Address St. Louis, 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.