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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 23 1947

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 16 1/2 hrs.
 In this community 3 yrs
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 105 E. 5 St.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Elmer Pierce

3. (b) If veteran, name war no 3. (c) Social Security No. 499-162968

4. Sex male 5. Color or race w 6. (a) Single, widowed, married, divorced Wid
 6. (b) Name of husband or wife Alice Pierce 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept-20-1884
 (Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Davenport Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation Electric Engineer

11. Industry or business _____

12. Name Samuel Pierce

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

14. Maiden name no record

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

16. (a) Informant Mrs. Helen Smith

(b) Address 6446 Monroe

17. (a) Burial (b) Date thereof June 9-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mr. C. R. Foster

(b) Address 918 Broadway

19. (a) 6-9-47 (b) Shelding Holmes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
 year 1947 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from June 5 1947 to June 6 1947
 that I last saw him im alive on June 6 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart disease with aortic stenosis and regurgitation

Due to _____

Due to _____

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

Major findings: _____
 Of operations _____

Of autopsy See above

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 Wm W Hart (M. D. or other) _____

Address Med. Dir. Gen'l Hosp. Date signed 8-6-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address..... *918 Brooklyn
R. C., 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.