No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43402

FILED DEC 31 1947

Registration District No. 318

Primary Registration District No. 1005

Registrar's No. 11547

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: 5596a Wells Ave.
(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. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5596a Wells Ave. 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 6
If yes, name country

3. (a) PRINT FULL NAME Catherine Pierce
3. (b) If veteran, name war –
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 Arthur Pierce
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased May (Month) 11 (Day) 1883 (Year)
8. AGE: Years 64 Months 7 Days ~~16~~ 6 If less than one day hr. min.
9. Birthplace Newport (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Patrick O'Neil
13. Birthplace Ireland 4 (City, town, or country) (State or foreign country)
14. Maiden name Bridget Nealis
15. Birthplace Ireland 4 (City, town, or county) (State or foreign country)
16. (a) Informant Mary De Rousse
(b) Address 2221 Benton, Granite City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge Ave.
19. (a) DEC 18 1947 (Date received local registrar) (b) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 17 year 1947 hour 5 minute A M.
21. I hereby certify that I attended the deceased from Sept. 19 46 to Dec. 15 19 47 that I last saw her alive on Dec. 15 19 47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	4 days.
Due to: Cardio-vascular-renal disease	1 yr.
Due to:	
Other conditions: Cardiac Asthma (Include pregnancy within 3 months of death)	1 yr.
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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 0
23. Signature Joseph F. Trigg (M. D. or other) M.D.
Address 408 N. Grand Blvd. Date signed 12/18/47
Joseph F Trigg

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 Ben E. Hoffman

Licensed Embalmer No. H-366

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.