

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED SEP 7 1949

State File No. 217787

No. 300
10.48

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3060 Registrar's No. 316

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)	
a. COUNTY <u>ST. FRANCOIS</u>	b. CITY OR TOWN <u>FARMINGTON</u>	a. STATE <u>MISSOURI</u>	b. COUNTY <u>ST. FRANCOIS</u>
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>FARMINGTON</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>8 South "A" STREET</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>EFFIE</u>	b. (Middle) <u>MYRTLE</u>	c. (Last) <u>PIETY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 22, 1949</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 1, 1884</u>	9. AGE (In years last birthday) <u>65</u>	10. UNDER 1 YEAR (Months) <u>6</u>	11. UNDER 24 HRS. (Days) <u>21</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>FAIRBANKS, INDIANA</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
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13a. FATHER'S NAME <u>GEORGE N. FULLER</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH THORN</u>	14. NAME OF HUSBAND OR WIFE <u>CHAUNCEY R. PIETY</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>CHAUNCEY R. PIETY</u>	ADDRESS <u>FARMINGTON MO.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MYOCARDIAL INFARCTION</u>		<u>2 WEEKS</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>NONE</u>		<u>YEARS</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>NONE</u>	<u>47 21</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG 5, 1949, to AUG 22, 1949, that I last saw the deceased alive on AUG 19, 1949, and that death occurred at 4:00 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James J. Faust M.D.</u>	23b. ADDRESS <u>Med. Bldg; Farmington, Mo.</u>	23c. DATE SIGNED <u>AUG 23, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>Aug 25, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sullivan Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Sullivan, Indiana</u>
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DATE REC'D BY LOCAL REG. <u>Aug 24, 1949</u>	REGISTRAR'S SIGNATURE <u>Ethel R. Rudolph</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Miller Funeral Home, Farmington, Mo.</u>	ADDRESS
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RECEIVED 8-27-49
District Health Officer No. 4
District File Number 849-1150
Date Filed _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Paul K. Dwyer

Licensed Embalmer No. 4120

P. O. Address Lawrence, 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.