

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

State File No. ....

No. 300  
10.48

FILED FEB 5 1954

BIRTH NO. .... REG. DIST. NO. 232 PRIMARY REG. DIST. NO. 3074 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (In this place) <u>2 Days</u>	c. CITY OR TOWN <u>Sikeston</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>218 N. Handy St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>James</u>	b. (Middle) <u>---</u>	c. (Last) <u>Pierce</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1 18 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>2-26-1868</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired CARPENTER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Sikeston, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Marion F. Pierce</u>	13b. MOTHER'S MAIDEN NAME <u>Griselda Pepper</u>	14. NAME OF HUSBAND OR WIFE <u>Willa Hammond</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John W. Marshall, Sikeston, Mo.</u>	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1-1-54</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio Vascular Rival Disease</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio Prostate Hypertrophy</u> <u>Causing urinary retention</u> DUE TO (c)		<u>2 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>610 X</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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I, hereby certify that I attended the deceased from 1-16, 1954, to 1-18, 1954, that I last saw the deceased alive on 1-18, 1954, and that death occurred at 10:10 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Thomas C. McClure, M.D.</u>	23b. ADDRESS <u>Sikeston, Mo.</u>	23c. DATE SIGNED <u>Jan 19-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>1-19-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City</u>	24d. LOCATION (City, town, or county) (State) <u>Sikeston MO</u>
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DATE REC'D BY LOCAL REG. <u>1-25-54</u>	REGISTRAR'S SIGNATURE <u>Mrs. Olat Linder</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welch Funeral Home Sikeston Mo</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 254-22  
FEB 1 1954

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 346

P. O. Address Sikeston

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.