

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015545

STATE FILE NUMBER  
Registration No. 2769

MAY 1 1959

Registration District No. Primary Registration District No.

300

-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS (If outside, give location) 4334a rear St. Louis Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Junus Westley Pierce		4. DATE OF DEATH Month Day Year March 16, 1959	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Fayette, Mo.
13a. FATHER'S NAME JUNIUS W. PIERCE SR.		13b. MOTHER'S MAIDEN NAME Leanna P	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Johnetta Jackson 4334a ST. LOUIS AVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bacteriemia DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 3 mo.			INTERVAL BETWEEN ONSET AND DEATH 1 wk.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 6000	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Dec. 17, 1958 to Mar. 16, 1959 Death occurred at 12:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John W. Beckham, M.D.		22b. ADDRESS 5800 Arsenal	
22c. DATE SIGNED 3/16/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3-20-59	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM	23d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO
24. FUNERAL DIRECTOR A.F. WALTON 2707 STODDARD ST.		25. DATE RECD. BY LOCAL REG. MAR 18 '59	26. REGISTRAR'S SIGNATURE Mae Pearl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *W. Claude Gordon* .....

Licensed Embalmer No. *3489* .....  
P. O. Address *4575 Aldine* .....

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.