

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042361

FILED VS DEC 7 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210496** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 weeks		c. CITY OR TOWN Jennings		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1927 Switzer Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Reuben Middle A. Last Pierce				4. DATE OF DEATH Month Nov. Day 13 Year 1959			
5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/5/1905	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturing Optician			10b. KIND OF BUSINESS OR INDUSTRY Eye Glasses		11. BIRTHPLACE (City and state or country) Oklahoma, Oklahoma		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Leroy Pierce			13b. MOTHER'S MAIDEN NAME Not Known			14. NAME OF HUSBAND OR WIFE Marcella Pierce	
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. 488-03-2759		17. INFORMANT Address Marcella Pierce 1927 Switzer 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) GENERALIZED METASTATIC SEMINOMA							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YEARS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) SEMINOMAS BOTH TESTICLES							6 YEARS
DUE TO (c) 178X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 11/6/57 to 11/13/59 and last saw ^{her} him alive on 11/12/59 Death occurred at 9:35 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Carl W. Smith, M.D.				22b. ADDRESS 6000 WEST FLORISSANT		22c. DATE SIGNED 11/13/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 11/14/59	23c. NAME OF CEMETERY OR CREMATORY East Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Springfield Mo.		
24. FUNERAL DIRECTOR ADDRESS Buchholz Mortuary 5967 W. Florissant				25. DATE RECD. BY LOCAL REG. NOV 14 1959		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Richard M. Rusk

Licensed Embalmer No. 4551
P. O. Address St. Louis

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.