

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9882-61-039075
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

AMENDED

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>1 yr.</u> <u>3 mo. 1 wk.</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2846 Pine St.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle Last <u>PIERCE</u>			4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>61</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> <u>unk</u> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-92</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (City and state or country) <u>Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Steven Pierce</u>		13b. MOTHER'S MAIDEN NAME <u>Addie ?</u>		14. NAME OF HUSBAND OR WIFE <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT <u>Chronic Hospital</u>	Address <u>5800 Arsenal</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT

DUE TO (b) GENERALIZED ARTERIOSCLEROSIS

DUE TO (c) 331 X H

INTERVAL BETWEEN ONSET AND DEATH
2-3 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
CARCINOMA OF PROSTATE

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 <u>7-7-60</u> to <u>10-14-61</u> and last saw her/him live on <u>10-14-61</u> Death occurred at <u>10:15</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>John J. Kerroy, M.D.</u>	(Degree or title)	22b. ADDRESS <u>5800 Arsenal Av</u>	22c. DATE SIGNED <u>10-16-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10-31-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>

24. FUNERAL DIRECTOR <u>KOWALSKI</u> <u>1104 Manchester Ave.</u> <u>St. Louis 10, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>OCT 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.