

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037169

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2664

FILED SEP 25 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>County St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park</u>		Length of stay in 1b <u>100 DAYS.</u>	c. CITY OR TOWN <u>Kirkwood</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Valley Park Nursing Home</u>		Inside Limits <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>123 East Washington</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie S Pierson</u>		4. DATE OF DEATH Month Day Year <u>Sept 13 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>91</u> Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>New Orleans Louisiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Henry Polkinghorne</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Hinch</u>	14. NAME OF HUSBAND OR WIFE <u>Chas. D. Pierson</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT Address <u>Carmen Curren 123 East Washington</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) <u>Broncho-Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <u>Generalized Arteriosclerosis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 s.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>Aug. 22, 1962</u> to <u>Sept. 13, 1962</u> and last saw her <u>alive</u> on <u>Sept. 13, 1962</u> Death occurred at <u>5:20 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert D. Sanders, M.D.</u>		22b. ADDRESS <u>1502 Cass Av</u>	22c. DATE SIGNED <u>9-14-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/17/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Lupton Chapel 7233 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>9-14-62</u>	26. REGISTRAR'S SIGNATURE <u>John Murphy M.D.</u>

Dr. Robert Sanderson  
1502 Cass  
CE19316

**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 Clarence A. Murray

Licensed Embalmer No. 4011

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