

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9494

1. PLACE OF DEATH

County Randolph Registration District No. 57 File No.
Township Primary Registration District No. 276 Registered No.
City Moberly (No. 3034) St. Ward)

2. FULL NAME

Samuel Preston Pierce
(a) Residence, No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/25 1926

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1926, to Feb. 25, 1926 that I last saw him alive on Feb. 25, 1926, and that death occurred, on the date stated above, at 12:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
angina pectoris
choles cystitis
(duration) yrs. mos. ds. 1 89
CONTRIBUTORY (SECONDARY) choles cystitis
(duration) yrs. mos. ds. 6

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH:
DID AN OPERATION PRECEDE DEATH: yes DATE OF 3/15-26

WHAT TEST CONFIRMED DIAGNOSIS:
(Signed) A. L. McCormick, M.D.
, 19 (Address) Moberly Mo.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Abeyonah's Cemetery 3/27 1927

20. UNDERTAKER ADDRESS
Fred W. Chouferson Moberly Mo.

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Esther Pierce

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/24 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 11 1

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Moberly Mo

10. NAME OF FATHER Robert P. Pierce

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER None of Bill

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

14. INFORMANT (Address) Mrs. Susan P. Pierce

15. FILED 4/10 1926 W. W. Edwards REGISTRAR

PARENTS

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No. File No.
 Township..... Primary Registration District No. Registered No.
 City..... (No.) SL..... Ward.....

2. FULL NAME

(a) Residence, No. St., Ward,
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (enter the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 13 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration) yrs. mos.

..... (duration) yrs. mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DATE OF.....

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., 19..... (Address) M. H.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL 19

20. UNDERTAKER

ADDRESS

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Randolph Registration District No. 735- File No. _____
 Township Westfork Primary Registration District No. 7034 Registered No. 86
 City Westfork (No. _____) St. _____ Ward _____

2. FULL NAME Sammie Preston Pierce
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Blanch Pierce

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 24 - 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
51 10 1

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Westfork Ark

10. NAME OF FATHER Robt Pierce

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ark

12. MAIDEN NAME OF MOTHER Martha Ball

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

14. INFORMANT Mrs Sammie J Pierce
 (Address) _____

15. FILED 5/14/26 Thos Fleming
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 - 1926

17. I HEREBY CERTIFY That I attended deceased from May 9 1926 to May 20 - 1926 that I last saw h. _____ all on May 20 - 1926, and that death occurred, on the date stated above, at Westfork Ark.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cholera typhoid

CONTRIBUTORY (SECONDARY) Cholera typhoid (duration) yrs. mos. ds. 1 da.
6 mos.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3-15-26

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) F. L. Mc Cormick, M. D.
3/26, 1926 (Address) Westfork Ark

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSE, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Alexander Sunday DATE OF BURIAL 3-27 1926

20. UNDERTAKER Fred a. Thompson ADDRESS Madison Ark

SUPPLEMENTARY

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Exact statement of Occurrence

ADDRESS
 CITY OF BURIAL
 COUNTY, STATE, AND COUNTRY
 NAME OF DEPARTMENT OF INFORMATION
 ADDRESS
 CITY OF DEPARTMENT OF INFORMATION
 COUNTY, STATE, AND COUNTRY
 NAME OF DEPARTMENT OF INFORMATION
 ADDRESS
 CITY OF DEPARTMENT OF INFORMATION
 COUNTY, STATE, AND COUNTRY
 NAME OF DEPARTMENT OF INFORMATION

will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus. But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatsoever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

S-9494

... may be indicated thus, ...
 Mrs.). For persons who have no occupation what-
 ever, write *None*.
 Name, first, the
 DISEASE CAUSING DEATH (the primary affection with
 respect to time and causation), using always the
 same accepted term for the same disease. Examples:
Cerebrospinal fever (the only definite synonym is
 "Epidemic cerebrospinal meningitis"); *Diphtheria*
 (avoid use of "Croup"); *Typhoid fever* (never report