

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Do not use this space.

42840

12633

1. PLACE OF DEATH

County.....

Registration District No. 1003

Township.....

Primary Registration District No.

City *St Louis* (No. *9432*)

File No.

Registered No.

St. Ward)

2. FULL NAME

(a) Residence. No. St. *5* 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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

M. H. Pierce

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

Feb 8th 1840

7. AGE

89

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

General Merchant

(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

John Pierce

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

England

12. MAIDEN NAME OF MOTHER

Mary Casey

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

PARENTS

14.

INFORMANT

(Address)

Katharine Pierce

9432 Beach Ave

15.

FILED

Max C. Starker

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12/26/29* 19

17. I HEREBY CERTIFY, That I attended deceased from *Dec. 2* 19*29* to *Dec 26* 19*29* that I last saw him alive on *Dec 26* 19*29*, and that death occurred, on the date stated above, at *9:15 PM* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

(duration) yrs. mos. ds. *10*

CONTRIBUTORY (SECONDARY) *Myocarditis Chronic*

(duration) yrs. mos. ds. *6*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Wm J. Langan*, M. D.

12/27. 1929 (Address) *2806 Grand Ave*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Frederntown Mo

12-28 1929

20. UNDERTAKER

ADDRESS

Arthur J. McConnelly 2039 Wash St

Let Mr. J. Lange =
2806 n Grand