

Registration District No. **5691** Primary Registration District No. **5691**

1. PLACE OF DEATH:  
(a) County **McDonald**  
(b) City or town **Rural Twp - Cyclone**  
(c) Name of hospital or institution: **5 miles east of Pineville, Mo.**  
(d) Length of stay: In hospital or institution **none**  
In this community **58 yr.**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **McDonald**  
(c) City or town **Rural - Cyclone, Mo**  
(d) Street No. **None**  
(e) If foreign born, how long in U. S. A. **20** years.

3. (a) PRINT FULL NAME **SAYAH ANN Piercee 620**  
(b) If veteran, name war **no**  
(c) Social Security No. **no**  
4. Sex **F**  
5. Color or race **W.**  
6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife **Newton Allen Piercee**  
6. (c) Age of husband or wife if alive **deceased** years  
7. Birth date of deceased **March 30 1888**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **October** day **9th**  
year **1939** hour **8:40** minute **1** A.M.  
21. I hereby certify that I attended the deceased from **Oct 2**, 1939, to **Oct 9th**, 1939;  
that I last saw him alive on **Oct 8**, 1939;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>57</b>	<b>6</b>	<b>9</b>	hr. min.

Immediate cause of death **1**  
**Myeloma Trans**  
**1st stage**  
Due to **night**

9. Birthplace **Green County Tenn.**

Due to

10. Usual occupation **hw.**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

Major findings: Of operations

12. Name **John H. Brown**

Of autopsy

13. Birthplace **Green County Tenn.**

14. Maiden name **Henery**

15. Birthplace **Tenn.**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant's own signature **John S. Piercee**

(b) Address **Ber Tenille, Va.**

17. (a) **Burial** (b) Date thereof **Oct 10, 1939**

(c) Place: burial or cremation **1**

18. (a) Signature of funeral director **Leo Leammell**

(b) Address **Pineville, Mo.**

19. (a) **10-9-39** (b) **Leo Leammell**

(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place)  
(c) Means of injury  
23. Signature **W. H. Foster** (M. D. or other)  
Address **Pineville** Date signed

Duration  
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

RECEIVED

District Health Officer No. 6,

District File Number 1139-2315

Date Filed NOV 10 1939

1942  
119

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

365917  
Do not use this space.

1. PLACE OF DEATH

(a) County McDonald Registration District No. 1149  
 (b) Township Cyflone Primary Registration District No. 5691 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah Ann Pierce

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
84 6 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

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

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

I last saw him alive on \_\_\_\_\_ 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Infection from small wound of arm & hand  
 Date of onset 10/6/39

Other contributory causes of importance:  
They noticed small scratch on hand but paid no attention several days later noticed considerable swelling & redness in a home in San Jose

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) W. H. Hayton, M. D.

(Address) Perceivable 2000

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

