DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39263

DEC 15 1939

Registration District No. 135 Primary Registration District No. 5191 Registrar's No. 139

1. PLACE OF DEATH:

(a) County Carroll.

(b) City or town RURAL - Sugartree Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: —

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community all his life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll.

(c) City or town "RURAL"
(If outside city or town limits, write "RURAL")

(d) ~~Street No.~~ Sugartree Twp.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME GALE HOWARD PIERSON 6.25

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Dec. (Month) 12 (Day) 1921. (Year)

8. AGE: Years 17 Months 11 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Carroll County (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Farmer

11. Industry or business —

FATHER
12. Name Joel F. Pierson
13. Birthplace Sweden. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jennie N. Ross
15. Birthplace Kingston (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Mrs Joe Pierson

(b) Address Carrollton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28. 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Gilead Cemetery

18. (a) Signature of funeral director Willis Marshall

(b) Address Carrollton Mo.

19. (a) 11-27-39 (Date received local registrar) (b) Ruth Hoskins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25th year 1939 hour Ten minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov. 15, 1939, to Nov. 25, 1939; that I last saw him alive on Nov. 25, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Lemon Lage

Due to Lasted entry.

~~Due to~~ (Carstoid)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

While at work? (e) Means of injury .....

23. Signature B. Hamilton Stokes (M. D. or other)

Address Cameron, Mo. Date signed Nov 27 39.

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 1 X19511

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. 8,
District File Number
Date Filed 12/6/34

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 MS.

....., Registered Apprentice No.....,

working under my personal supervision.

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton 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 this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
I X22659

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

ROWENA MOORE

Special

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 39263-

Registration District No. 138 Primary Registration District No. 5191 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Carroll-
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Gale H. Pierson

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced P-
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 11-18-39 (Date received local registrar) (b) Ruth Haskins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 25 day 1939
year hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage of carotid artery -	
Due to strep. infection	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed