

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19986

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **4934**

1. PLACE OF DEATH: **St. Louis, Missouri**

(a) County _____

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **City Sanitarium**
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution **1 year 11 days.**
In this community **About 40 years** (Specify whether years, months or days)

8. (a) PRINT FULL NAME: **Gusta M. Pierce** **620**

8. (b) If veteran, name war: **No**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife: **Frank Pierce** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **Feb. 17, 1881**
(Month) (Day) (Year)

8. AGE: Years 59	Months 3	Days 17	If less than one day hr. _____ min. _____
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9. Birthplace: **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Nil**

11. Industry or business: _____

12. Name: **Unknown**

13. Birthplace: **Unknown** **England**
(City, town, or county) (State or foreign country)

14. Maiden name: **Unknown** **England**

15. Birthplace: **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant: **A. Legendre**

(b) Address: **5300 Ashland**

17. (a) **ASHLAND** (b) Date thereof: **June 6-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **MOUNT HOPE CEMETERY**

18. (a) Signature of funeral director: **Joseph H. ...**

(b) Address: **1420 Michigan St.**

19. (a) **JUN 5 1940** (b) _____
(Date received local registrar) (Registrar's initials)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **620 Lynch St.**
5400 Grand St. (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **3**
year **1940** hour **11:45** minute _____ P. M.

21. I hereby certify that I attended the deceased from **10-24-38** 19____ to **6-3-40** 19____;
that I last saw **her** alive on **6-3-40** 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: **General Paralysis of the Insane (onset 1938 x)**

Due to: **Syphilis (onset 1938x)**

Due to: _____

Other conditions: **83**
(Include pregnancy within 3 months of death)

Major findings: **83**

Of operations: _____

Of autopsy: **No**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: **Anthony K. Busch, M.D.** (M. D. or other) _____

Address: **City Sanitarium** Date signed _____

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Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Wilson Collins

Licensed Embalmer No. *3787*

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