

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1383

Registration District No. 399

Primary Registration District No. 1002

State File No. _____

Registrar's No. 124

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Children's Mercy Hospital
(If not in hospital or institution, write street number of location)
 (d) Length of stay: In hospital or institution 1 month
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Jay
 (c) City or town Atchison
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 2

3. (a) PRINT FULL NAME

William Pierce

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 Child
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 5 1941
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>2</u>	<u>6</u>	_____ hr. _____ min.

9. Birthplace Atchison 1 Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name William E. Pierce
 13. Birthplace _____ 9
(City, town, or county) (State or foreign country)
 14. Maiden name FRANCES
 15. Birthplace _____ 9
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-11-42 (b) M. B. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
 year 1942 hour 8 minute 50 P.M.

21. I hereby certify that I attended the deceased from Jan 10 1942 to Jan 10 1942
 that I last saw him alive on Jan 10 1942 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to Intestinal Obstruction
Intussusception

Due to _____
 Other conditions 122
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy None

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 W. S. Sodenberg (M. D. or other) _____
 Address 1315 1/2 St Date signed Jan 10 1942

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

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, fact should be so stated above.