S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26025

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7659

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Missouri Baptist Hospital
(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 Illinois (b) County Clay 999 N.R.

(c) City or town Xenia 11
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Fidella V. Peirce

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife John A. Peirce

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

7. Birth date of deceased May (Month) 24 (Day) 1848 (Year)

8. AGE: Years 97 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Wayne County (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name J.P. Westmoreland
13. Birthplace Unknown (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Elizabeth Thompson
15. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mrs. Jane Bradley
(b) Address Xenia, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Xenia, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 1 (Date received local registrar) (b) 1945 J.F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30 year 1945 hour 4 02 minute P M.

21. I hereby certify that I attended the deceased from 8-25-, 1945, to 8-30-, 1945 that I last saw her alive on 8-30-, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobular Pneumonia Terminal	2 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Fracture Rt Hip a	5 days
Major findings: Of operations 186	
Of autopsy 18	

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) Fall at home Clay Co
(b) Date of occurrence 8-25-45
(c) Where did injury occur? Fall at home (City or town) Xenia (County) Ill (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at her home (Specify type of place)
While at work? (e) Means of injury fall

23. Signature [signature] (M.D. or other)
Address 4500 Olive St Louis Mo Date signed 8/31/45

(Licensed Embalmer's Statement on Reverse Side)

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 John Ogonoski

Licensed Embalmer No. 3398

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.