

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 24 1946** STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

32095

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8039**

1. PLACE OF DEATH:

(a) County..... **St. Louis**

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

(c) Name of hospital or institution:  
**Barnes 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 **Missouri** (b) County..... **000**

(c) City or town..... **St. Louis** **1917**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3887** **Washington Blvd.** **9**  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No) **0**  
If yes, name country.....

3. (a) PRINT FULL NAME **Charles V. Pearce**

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

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

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Haskell Pearce**

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

7. Birth date of deceased **August 28 1910**  
(Month) (Day) (Year)

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

**36 0 18** hr. min.

9. Birthplace **Madisonville Kentucky**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Elevator Operator**

11. Industry or business.....

12. Name **Guy Pearce**

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

14. Maiden name **Minnie Brigham**

15. Birthplace **Madisonville Kentucky**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter Pearce**

(b) Address **3887 Washington Blvd.**

17. (a) **Removal** (b) Date thereof **9-17-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Marion, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **SEP 17 1946** (b) **J. Bredeck**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **16**  
year **1946** hour **11** minute **45** A.M.

21. I hereby certify that I attended the deceased from **7**....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: **Fracture of Skull**  
**2 Laceration of brain when they**  
**emerged in battle for joust and**  
**one of the elevators he was about to**  
**be used by one of his names**  
**operating this to be caught between**  
**the top of the elevator and the**  
**second floor and thrown back**  
**into the bottom of the elevator shaft**  
**Major and Mrs. Murren Athletic Club**  
**around 8:45 A.M. Sept. 14, 1946**

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy..... **1862**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **Sept 16 1946**

(c) Where injury occurred **St. Louis**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Work to done**  
(Specify type of place) (e) Means of injury

23. Signature **Dr. Reginald Perry** (M. D. or other)  
Address **St. Louis** Date signed **9/17/46**

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

43

30920

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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 J. Dennehy*  
Licensed Embalmer No. *4694*  
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, fact should be so stated above.