

S. No. 2  
-1/47  
5-17-39

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32909**  
Registrar's No. **8907**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town **St. Louis, Missouri**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **Alexian Brothers 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 **Madison**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4050 California Avenue.**  
**15** (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **William Thomas Pierson**  
3. (b) If veteran, name war..... **None**  
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept** day **20th**  
year **1947** hour **9** minute **20 A.M.**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Bessie Pierson**  
6. (c) Age of husband or wife if alive..... years **1869**  
7. Birth date of deceased **August 5 1869**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept. 1946** to **ghoul date**  
that I last saw him alive on **sept. 20 1947**  
and that death occurred on the date and hour stated above.  
Duration

8. AGE: Years Months Days If less than one day  
**78 1 15** hr. min.

Immediate cause of death  
**1) Rupture chordae tendinae**  
Due to **arteriosclerosis**

9. Birthplace **Paducah Kentucky 1**  
(City, town, or county) (State or foreign country)

Due to **Hypostatic pneumonia** 5 Da.

10. Usual occupation **Farmer**

Other conditions.....  
(Include pregnancy within 3 months of death)

11. Industry or business **Farming**

Major findings: Of operations.....

12. Name **Unknown Pierson**

Of autops: **as above**  
PHYSICIAN  
Underline the cause of which death should be charged statistically.

13. Birthplace **Unknown Unknown 9**  
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown Unknown 9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Atha Coleman**

(b) Address **7353 Trenton Avenue.**

17. (a) **Burial** (b) Date thereof **9/22/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bismarck, Missouri**

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

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

19. (a) **SEP 23 1947** (b) **J. F. Bredack**  
(Date received local registrar) (Registrar's signature)

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?..... (c) Means of injury.....  
23. Signature **L. E. Welsh** (M. D. or other) **MD.**  
Address **4530 Chouteau** Date signed **9/23/47**

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

MOTHER FATHER

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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..... *Henry M. Brammer* .....

..... Licensed Embalmer No. *4200* .....

..... P. O. Address *St. Louis* .....

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.