V. S. No. 2
0M—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40393

FILED NOV 29 1947

Registration District No. 377

Primary Registration District No. 3063

Registrar's No. 2439

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hours (Specify whether
In this community 3 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Maryland Hts.
(If outside city or town limits, write "RURAL")
(d) Street No. 148 Cumberland Avenue
(If rural, give location)
(e) Citizen of foreign country? - no - (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Nancy Pierce
3. (b) If veteran, name war Nil
3. (c) Social Security No. None
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Thomas F. Pierce
6. (c) Age of husband or wife if alive years
7. Birth date of deceased February (Month) 23 (Day) 1877 (Year)

8. AGE: Years 70 Months 9 Days 1 If less than one day hr. min.

9. Birthplace Ware (City, town, or county) Missouri (State or foreign country)
10. Usual occupation house-wife
11. Industry or business at home
FATHER
12. Name Solomon Knapp
13. Birthplace (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Mary Giddeon
15. Birthplace (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Phillip Rogers
(b) Address 5635 Willard Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation Ware, Missouri
18. (a) Signature of funeral director A W McLaughlin
(b) Address 2301 LaFayette Ave
19. (a) 11-28-47 (Date received local registrar) (b) Cecil J. Shaff MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24
year 1947 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 11-24-47 2:30 pm 19 to 11-24-47 9:30 PM;
that I last saw her alive on 11-24-47 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Vascular Accident c̄ left hemiparesis	1 day
Due to 93d	
Due to	
Other conditions (Include pregnancy within 3 months of death) Hypertensive Cardiac disease c̄ auricular fibrillation	9

Major findings:
Of operations
Of autopsy

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

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? (e) Means of injury

23. Signature A. Iohn, MD (M. D. or [redacted])
Address Brentwood Blvd Date signed 11-24-47

Jefferson City Printing Co.

(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 C. W. Cooper

Licensed Embalmer No. 3850

P. O. Address 2301 Lafayette Avenue

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.