

PIERSON
FILED APR 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14596
3532

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2209	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Little Sisters of Poor		d. STREET ADDRESS (If rural, give location) 0 3225 N. Florissant Ave.	

3. NAME OF DECEASED (Type or Print) Stella I. Pierson		4. DATE OF DEATH (Month) (Day) (Year) Apr. 14, 1951	
5. SEX F.		6. COLOR OR RACE W.	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W. <input checked="" type="checkbox"/>		8. DATE OF BIRTH Apr. 8, 1873	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Days 06	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		11. BIRTHPLACE (State or foreign country) Levenworth, Arkansas	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME William Scott	13b. MOTHER'S MAIDEN NAME Prudence Smith	14. NAME OF HUSBAND OR WIFE Mr. Samuel Pierson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. James A. Pierson, 3841 Scherman Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH ???
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) None DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death None			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) None	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 412.2
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22. I hereby certify that I attended the deceased from April 2, 1951, to April 14, 1951, that I last saw the deceased alive on April 14, 1951, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Signed on title) Samuel H. Love MD	23b. ADDRESS 2435 N. Grand St.	23c. DATE SIGNED 4-15-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial (1)	24b. DATE Apr. 16, 1951	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. APR 16 1951	REGISTRAR'S SIGNATURE J. B. Casster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.
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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.....

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed.....

Thomas R. Fenwick

Licensed Embalmer No.

3793.

P. O. Address.....

3840 Lindell

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.