

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25645**

FILED JUL 16 1951

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3069** Registrar's No. **2571**

1. PLACE OF DEATH a. COUNTY St. Louis 4005		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri St. Louis COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis MO.) RICHMOND #675		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital...		d. STREET ADDRESS (If rural, give location) #3417 Lemp Street...!	

3. NAME OF DECEASED (Type or Print) a. (First) Richard E. b. (Middle) Pierce c. (Last) Pierce	4. DATE OF DEATH (Month) (Day) (Year) July 4th 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH Sept. 9th 1944	9. AGE (In years last birthday) 6	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) East St. Louis	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Pierce	13b. MOTHER'S MAIDEN NAME Dorothy Warren	14. NAME OF HUSBAND OR WIFE X None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Dorothy Paul Adams	ADDRESS 2
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Astrocytoma of Cerebellum		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		193X	

19a. DATE OF OPERATION July 3 1951	19b. MAJOR FINDINGS OF OPERATION Astrocytoma of Cerebellum	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 29, 1951**, to **July 4, 1951**, that I last saw the deceased alive on **July 4, 1951**, and that death occurred at **3:30 AM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul G. Fitch, M.D.	23b. ADDRESS St. Marys Hospital	23c. DATE SIGNED July 5 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-4-1951	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemty.	24d. LOCATION (City, town, or county) (State) Belleville, Illinois
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DATE REC'D BY LOCAL REG 7-5-51	REGISTRAR'S SIGNATURE Hubert R. Lonke	25. FUNERAL DIRECTOR'S SIGNATURE G. M. Bruehler	ADDRESS St. Louis Ill.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

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 IMO

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ben H. Baldwin

Licensed Embalmer No. 2420

P. O. Address E. H. Harris, Ill

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.