

FILED APR 25 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

14657

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3222**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI 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	
c. LENGTH OF STAY (in this place)		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4924 ST. LOUIS AVE		d. STREET ADDRESS (If rural, give location) 4924 ST. LOUIS AVE	

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) F. A. c. (Last) Pierce			4. DATE OF DEATH (Month) (Day) (Year) 4-4-1952		
5. SEX ♂	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH 9-2-1875	9. AGE (In years last birthday) 76	10. MONTHS 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chiropractor		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) 9	
12. CITIZEN OF WHAT COUNTRY?		Not Known			

13a. FATHER'S NAME Not Known	13b. MOTHER'S MAIDEN NAME Not Known	14. NAME OF HUSBAND OR WIFE Josephine
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 M. C. Gail
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		18. ADDRESS

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of cardiac end of stomach		INTERVAL BETWEEN ONSET AND DEATH 19 months
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		

19a. DATE OF OPERATION March 15, 1952	19b. MAJOR FINDINGS OF OPERATION Card obstruction of inlet Esophagus	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 151X

22. I hereby certify that I attended the deceased from **March 15, 1952** to **April 4, 1952**, that I last saw the deceased alive on **April 3, 1952**, and that death occurred at **9:50 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph Davie M.D.	23b. ADDRESS 406 Finco Bldg	23c. DATE SIGNED 4-5-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-7-52	24c. NAME OF CEMETERY OR CREMATORY St. Hope Cemetery
24d. LOCATION (City, town, or county) (State) East St. Louis Ill.		

DATE REC'D BY LOCAL REG. APR 7 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE A. Kouli H. Co	ADDRESS 1707 N. Grand
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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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.....
J. W. Duteal
Licensed Embalmer No. *4329*
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.