

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006806

STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre, Mo.</b>		c. CITY OR TOWN <b>Bonne Terre, Mo.</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence</b>		Length of stay in 1b <b>Six Months</b>	
3. NAME OF DECEASED (Type or print) <b>Drew C. Pierce</b>		4. DATE OF DEATH <b>Feb 16, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> - DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (City and state or country) <b>St. James, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Cramer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>499-03-6318</b>	
17. INFORMANT <b>Lucille Pierce, Bonne Terre, Mo.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Multiple Sclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) _____			INTERVAL BETWEEN ONSET AND DEATH <b>331X</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>April 1-1958</b> to <b>Feb 15-1959</b> and last saw <sup>her</sup> him alive on <b>Feb 15, 1959</b> Death occurred at <b>12:15 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD. J. Bonne Terre - Mo.</b>		22b. ADDRESS <b>Bonne Terre - Mo.</b>	
22c. DATE SIGNED <b>2-16-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-18-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bonne Terre</b>	23d. LOCATION (City, town, or county) (State) <b>Bonne Terre, Mo.</b>
24. FUNERAL DIRECTOR <b>Sparks Funeral Home, Bonne Terre, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Feb 17, 1959</b>	
ADDRESS		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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.....  
Signature of Student Embalmer

Signed *John N. Shipman*  
Licensed Embalmer No. *48*

P. O. Address *Bioman*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.