

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014521

STATE FILE NUMBER

Health, Welfare  
Public  
Service

Filed **MAY 6 1959** Registration District No. **301** Primary Registration District No. \_\_\_\_\_ Registrar's No. **29**

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Ripley</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Ripley</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Doniphan</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Doniphan</b> <b>0910</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>801 Pine St.</b>		Length of stay in lb <b>63 years</b>	d. STREET ADDRESS (If outside, give location) <b>801 Pine St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Eliza</b> Middle <b>JANE</b> Last <b>Pierce</b>			4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>Female</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>DEC. 24, 1864</b>		9. AGE (In years <b>94</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Month Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Middlebrook, Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Daniel Spence</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Jones</b>		14. NAME OF HUSBAND OR WIFE <b>Riley Pierce</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MRS. ORA FREEMAN Doniphan, Mo.</b> Address <b>R#6</b>		

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 Hemorhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized arteriosclerosis</b>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <b>1956</b> to <b>April 5, 1959</b> and last saw <sup>her</sup> <b>him</b> alive on <b>April 3, 1959</b> Death occurred at <b>11:00 A.</b> m on the date stated above; and to the best of my knowledge from the causes stated.			

22a. SIGNATURE <b>Frank C Johnson M.D.</b> (Degree or title)		22b. ADDRESS <b>Doniphan Mo</b>		22c. DATE SIGNED <b>4/7/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 6, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Doniphan Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Doniphan Missouri</b>

24. FUNERAL DIRECTOR <b>Edwards Funeral Home</b>	ADDRESS <b>Doniphan Mo</b>	25. DATE RECD. BY LOCAL REG. <b>May-3-1959</b>	26. REGISTRAR'S SIGNATURE <b>Flava Brog</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 *Gene Harrent*

Licensed Embalmer No. *4809*  
P. O. Address *Naylor, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.