

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036750**

**FILED VS OCT 28 1959**

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. \_\_\_\_\_ Registrar's No. 158

ENDED

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

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Calvin</u> Last <u>Pierce</u>			4. DATE OF DEATH Month, Day, Year <u>Oct. 22, 1959</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/1872</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Pulaski Co. Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Joseph H. Pierce</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Elam</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Ellen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-12-4421</u>		17. INFORMANT <u>Edmund Pierce Falcon Mo.</u> Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>		<u>22 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic heart dis.</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 2-22-58 to 10-22-59 and last saw <sup>her</sup>him alive on 6-12-59  
Death occurred at 8:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>B B Hurst M.D.</u> (Degree or title)	22b. ADDRESS <u>Lebanon, Mo.</u>	22c. DATE SIGNED <u>10-23-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/25/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cross Roads Cemetery Laclede Co. Mo.</u>	23d. LOCATION (City, town, or county) <u>Laclede Co. Mo.</u> (State)
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24. FUNERAL DIRECTOR <u>Dorsey M. Howe</u> ADDRESS <u>Lebanon, Mo. 10-23-1959</u>	25. DATE RECD. BY LOCAL REG. <u>10-23-1959</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Hloy</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Dorsey M. Howe

Licensed Embalmer No. 422

P. O. Address Lebanon

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.