URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 1 0 1960

-60-040094

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10598

NDED

11/16/60

82

78

9

Birth certificate from Illinois

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 30 min.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois
b. COUNTY: Bond
c. CITY OR TOWN: Keyesport
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): none
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Maude Middle E. Last Pierson
4. DATE OF DEATH: Month November Day 1 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/23/~~1878~~ 1882
9. AGE (last birthday): 78 ~~82~~
IF UNDER 1 YEAR: Months 2 Days 9
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Keyesport, Illinois
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: George L. Pierson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: James R. Day Address: Carlyle Ill.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 331.1
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11/1/60 to 11/1/60 and last saw her/him alive on 11/1/60
Death occurred at 8:50 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [illegible] M.D.
22b. ADDRESS: 100 No Euclid St. Louis Mo
22c. DATE SIGNED: 11-2-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Rem. to Madison, Ill.
23b. DATE: 11/4/60
23c. NAME OF CEMETERY OR CREMATORY: McKendree Chapel
23d. LOCATION (City, town, or county) (State): Bond County, Illinois

24. FUNERAL DIRECTOR: [illegible] Madison
ADDRESS
25. DATE RECD. BY LOCAL REG.: NOV 2 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Francis J. Lahey

Signature of Student Embalmer

Licensed Embalmer No. 279

P. O. Address Madison

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.