

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1961

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834-61-003536

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

AMENDED

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3715 Page</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lola</b> Middle Last <b>Pierson</b>			4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</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>Apr. 14, 1887</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>11</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nit.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (City and state or country) <b>SPARTA Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>WM BRITTON</b>		13b. MOTHER'S MAIDEN NAME <b>LIZZIE JONES</b>		14. NAME OF HUSBAND OR WIFE <b>John Pierson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>NETTIE WOODS 3715 PAGE</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>Carcinoma of Ovary</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)			DUE TO (c) <b>1750</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Adenocarcinoma</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>	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>10-13-60</b> to <b>1-25-60</b> and last saw <input checked="" type="checkbox"/> alive on <b>1-25-60</b>		Death occurred at <b>2:45</b> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or Title) <b>J. P. ... M.D.</b>		22b. ADDRESS <b>2601 N. Whittier St.</b>		22c. DATE SIGNED <b>1-26-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JAN. 30-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>ST LOUIS CO, MO</b>		
24. FUNERAL DIRECTOR <b>A.F. WALTON 2707 Stoddard</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 27 1961</b>	26. REGISTRAR'S SIGNATURE <b>Kearl Smith M.D.</b>		

ISSUED BY

DATE

TIME

DATE

TIME

**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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Taylor

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.