

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

40239  
40329

**1. PLACE OF DEATH**

County Cape Girardeau  
Township Boyer  
City Marion Mo.

Registration District No. 124  
Primary Registration District No. 5179

File No. ....  
Registered No. 49 .....

**2. FULL NAME**

(a) Residence, No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charllette Brooks Pierce

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 20 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
76 6 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Gardner

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Girardeau Mo.

13. NAME Geo Pierce

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

15. MAIDEN NAME Anna M. Sud

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Joe Lasch (ADDRESS) Marion Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Old M. & K. cemetery DATE Dec 7 1931

19. UNDERTAKER M. Combs & Sons & Sons Co. (ADDRESS) Marion Mo.

20. FILED 12-7 1931 R. G. Schubert Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 5, 1931

22. I HEREBY CERTIFY, That I attended deceased from Dec 4 1930 to Dec 4 1931

I last saw him alive on Dec 4, 1931 Death is said to have occurred on the date stated above, at 8 P m.

The principal cause of death and related causes of importance were as follows:

Pareumonia of left lower lung & abscess attended with metastasis

Other contributory causes of importance:

53E

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

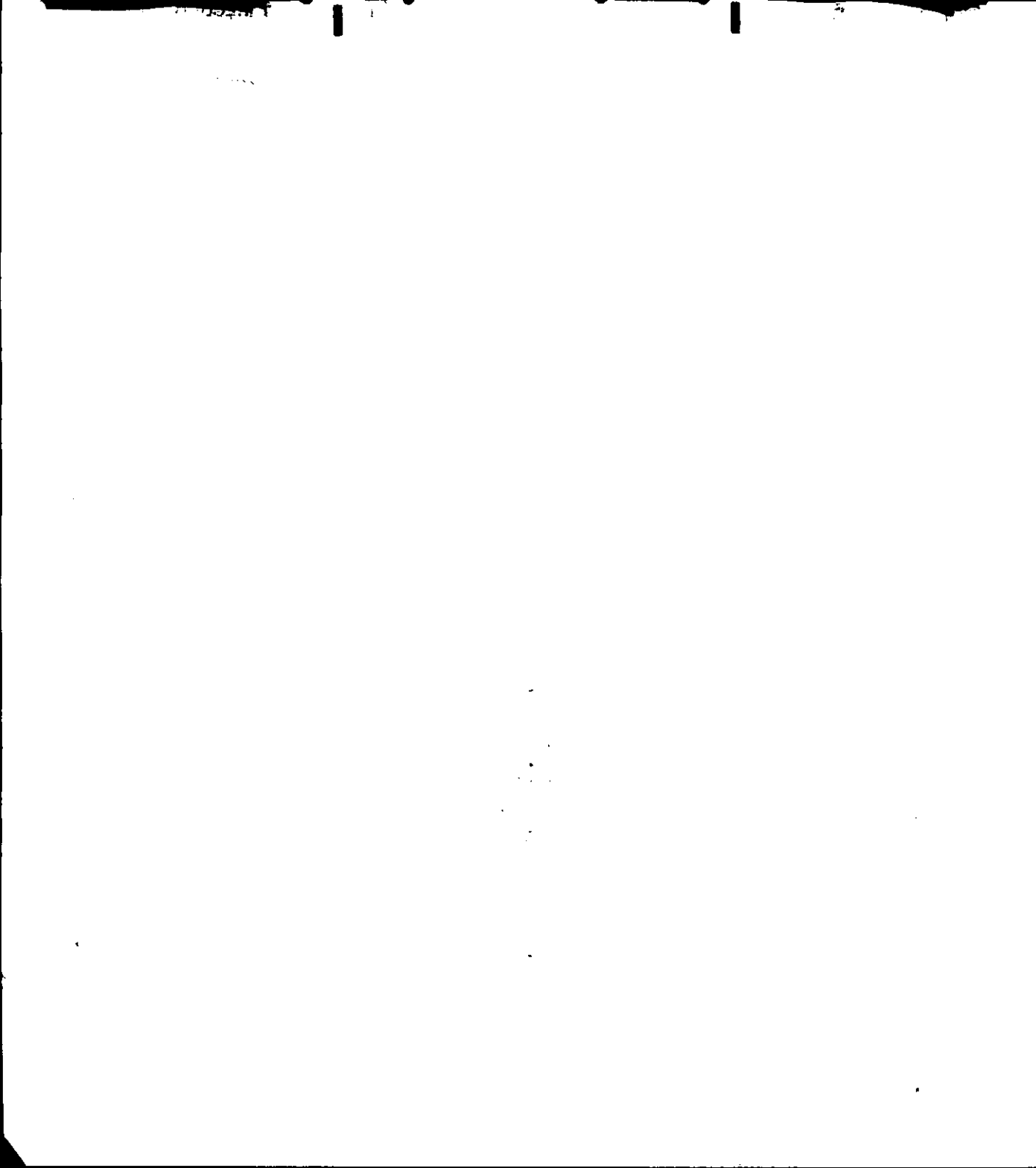
Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify.....

(Signed) J. W. Hays, M. D.  
(Address) Marion, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 19 1932



requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

49

Name: John W. Pierce

Who died at: Cape Girardeau, Mo. Dec. 5, 1931

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Carcinoma of left lower quadrant of abdomen attended with metastasis.

Contributory: Abdominal wall (Inguinal region)

Where was disease contracted? \_\_\_\_\_

Did operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

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