

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030847

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2046

STATE FILE NUMBER

FILED JUL 22 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester</u>		Length of stay in 1b <u>16 Months</u>	c. CITY OR TOWN <u>Charlack</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manchester Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2440 Bristow</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>F.</u> Last <u>Pigg</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/1873</u>
9. AGE (last birthday) <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Shelbyville Illinois</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Abraham Herod</u>		13b. MOTHER'S MAIDEN NAME <u>Mary F. Carrow</u>	
14. NAME OF HUSBAND OR WIFE <u>The Late Richard Pigg</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>None</u>		17. INFORMANT <u>Mary Moore</u> Address <u>2440 Bristow</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> DUE TO (b) <u>CHRONIC NEPHRITIS</u> DUE TO (c) <u>SENILITY</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last.			INTERVAL BETWEEN ONSET AND DEATH <u>3</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NONE</u>			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 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 <u>4-8-63</u> to <u>6-25-63</u> and last saw her ^{him} alive on <u>6-24-63</u> Death occurred at <u>1:05 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dagrees or title) <u>B.R. Loving, M.D.</u>		22b. ADDRESS <u>BALLWIN, Mo.</u>	22c. DATE SIGNED <u>6-25-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>	23b. DATE <u>6/27/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Herod Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Des Loge Mo.</u>
24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-26-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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

Sheldon Collins

Licensed Embalmer No.

3382

P. O. Address

St. Ann 2000.

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.

JAN 1951