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0M—8-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

27298

State File No.

FILED AUG 20 1945

Registration District No. 07 Primary Registration District No. 3019 Registrar's No. 77

**1. PLACE OF DEATH:**

(a) County DUNKLIN

(b) City or town KENNETT
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: PRESNELL HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 DAYS (Specify whether
In this community ALL OF LIFE years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County DUNKLIN 35

(c) City or town CLARKTON 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME RICKIE VAN PIGMON

3. (b) If veteran, name war NO.

3. (c) Social Security No. NO.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced INFANT

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive years

7. Birth date of deceased FEBRUARY (Month) 18 (Day) 1945 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 5 | 9 | hr. min. |

9. Birthplace MALDEN (City, town, or county) MO. (State or foreign country)

10. Usual occupation INFANT

11. Industry or business NONE

FATHER
12. Name HERSHEL PIGMON
13. Birthplace HORNERSVILLE (City, town, or county) MO. (State or foreign country)

MOTHER
14. Maiden name HALLIE STOCKTON
15. Birthplace HOLCOMB (City, town, or county) MO. (State or foreign country)

16. (a) Informant HALLIE PIGMON

(b) Address CLARKTON, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-28-45 (Month) (Day) (Year)

(c) Place: burial or cremation SUMAC ~~SCHUMAKE~~ CEMETERY

18. (a) Signature of funeral director DAY FUNERAL HOME

(b) Address MALDEN, MO.

19. (a) 7-30-45 (Date received local registrar) (b) Julia Blankenship (Registrar's signature)

401

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 27th year 1945 - 5 hour 30 minute A M.

21. I hereby certify that I attended the deceased from 7-15, 1945, to 7-27-, 1945, that I last saw him alive on 7-22, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition

Due to Pyloric Stenosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 1579
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature G C Wilson (M. D. or other) MD

Address Kennett Mo. Date signed 7-27-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 845-105
Date Filed 8-8-45

**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 NOT EMBALMED, Registered Apprentice No. ....., working under my personal supervision.

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

**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 this body is not embalmed, fact should be so stated above.**