

Health, Welfare & Public Service  
 300 1-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 24 1956

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1003

STATE FILE NUMBER 22073  
 6570  
 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS <b>4362 Olive</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Lavenia Piggott</b>			4. DATE OF DEATH <b>July 12, 1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>June 30/1871</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Louisiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown Powell</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</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.	17. INFORMANT <b>Galvin Piggott 3969 Fillmore St.</b>		
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>Fracture of Right Hip</b> <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Suffered in fall at Chronic Hospital July 7<sup>th</sup> - 1956</b> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Accident</b>					INTERVAL BETWEEN ONSET AND DEATH <b>45</b>
20a. ACCIDENT <input checked="" 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.) <b>fell at Chronic Hospital 9:047</b>			
20c. TIME OF INJURY Hour a. m. p. m. <b>7-7-56</b>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>		20g. COUNTY STATE	
21. I attended the deceased from <b>8:30 p.</b> to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Samuel B. Taylor</b>			22b. ADDRESS <b>31300 Clark Ave</b>		22c. DATE SIGNED <b>7/13/56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/16/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Lemay, Missouri</b>
24. FUNERAL DIRECTOR <b>Edward Fendler</b>		ADDRESS <b>5611 South Grand Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 13 1956</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith Mo</b>

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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, *Harry J. Schenck*  
Licensed Embalmer No... 26

P. O. Address *5611 S*

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