

**FILED MAR 10 1959** 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>915 N. GRAND ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		Length of stay in lb <b>21 Days</b>	d. STREET ADDRESS (If outside, give location) <b>3645 A BATES</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>COLIN</b> Middle <b>W</b> Last <b>PIKE</b>			4. DATE OF DEATH Month <b>2-</b> Day <b>17-</b> Year <b>59</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-07</b>
9. AGE (In years last birthday) <b>51</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(retired) Master Sergeant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	11. BIRTHPLACE (City and state or country) <b>MARVIN GEORGIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>GEORGE W. PIKE</b>	13b. MOTHER'S MAIDEN NAME <b>MARY MC CREE</b>
14. NAME OF HUSBAND OR WIFE <b>DOROTHY PIKE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>WW-II</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>VAH RECORDS 915 N. GRAND ST. LOUIS, MO.</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>BRONCHOPNEUMONIA</b> Interval between ONSET AND DEATH <b>21 Days</b> DUE TO (b) <b>DYSPHAGIA AND ASPIRATION</b> Interval <b>23 Days</b> DUE TO (c) <b>HUNTINGTONS CHOREA</b> <b>355X</b> Interval <b>12 Years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION <b>ST. LOUIS</b>		20f. COUNTY STATE <b>MISSOURI</b>	
20g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20h. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from <b>1-27-59</b> to <b>2-17-59</b> and last saw him live on <b>2/17/59</b> Death occurred at <b>6:45 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert K. Lane</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>VAH 915 N. GRAND ST. LOUIS, MO.</b>	
22c. DATE SIGNED <b>2/17/59</b>		22d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Feb. 19, 1959</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
24. FUNERAL DIRECTOR <b>WACKER-HELDERLE-3634</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 19 '59</b>	
26. ADDRESS <b>Gravois Ave.</b>		26. REGISTRAR'S SIGNATURE <b>Robert Smith, M.D.</b>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57  
74

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 .....  
Licensed Embalmer No. 2675  
P. O. Address Dr. Foristner

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.