

STANDARD CERTIFICATE OF DEATH

State File No. **35286**

FILED NOV 15 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9313**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (in this place) 6 months		c. CITY OR TOWN Eureka Rt		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Walton Nursing home				e. STREET ADDRESS (If rural, give location) # 007			
3. NAME OF DECEASED (Type or Print) Nellie		a. (First)		b. (Middle) Elizabeth		c. (Last) Wigger	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 11-3-1879	
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		9. AGE (In years last birthday) 76		11. BIRTHPLACE (City and State or Foreign Country) Hopewell, Missouri	
13a. FATHER'S NAME James Armstrong		13b. MOTHER'S MAIDEN NAME Nancey Bone		14. NAME OF HUSBAND OR WIFE Joseph A. Wigger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS James I. Wigger St Louis, Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) metastatic insufficiency ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Liver DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION 156.1			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1, 1955 , to Oct 17, 1955 , that I last saw the deceased alive on Oct 17, 1955 , and that death occurred at 630A m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) O. O. Major M.D.				23b. ADDRESS 6029 S. Kings Highway		23c. DATE SIGNED Oct 25, 55	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 10-26-1955		24c. NAME OF CEMETERY OR CREMATORY Hopewell cemetery		24d. LOCATION (City, town, or county) (State) Hopewell, Mo	
DATE REC'D BY LOCAL REG. OCT 25 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE W. H. Smith		ADDRESS Potosi, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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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
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Mary M. Smith*
Licensed Embalmer No. *4*

P. O. Address *Pataci...*

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.