

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-014808
STATE FILE NUMBERDO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 120 Primary Registration District No. _____ Registrar's No. 44

FILED APR 25 1962

1. PLACE OF DEATH a. COUNTY <u>Gentry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Albany</u>		Length of stay in 1b <u>5 years</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>304 S. Seventh</u>		d. STREET ADDRESS (If outside, give location) <u>304 S. Seventh</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Ray</u> Last <u>Pigg</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optometrist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Optometry</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13a. FATHER'S NAME <u>Ben F. Pigg</u>		13b. MOTHER'S MAIDEN NAME <u>Mabel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. Ray Pigg Albany, Mo.</u>		14. NAME OF HUSBAND OR WIFE <u>Joyce Guess PIGG</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>Gastrointestinal Hemorrhage</u> Conditions, if any, which gave rise to, above cause (a), stating the underlying cause last. DUE TO (b) <u>Peptic Ulcer</u> DUE TO (c) <u>Undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Asthma, emphysema, bronchiectasis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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. Month, Day, Year _____		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 <u>Albany, Missouri</u>	
21. I attended the deceased from <u>3-29-62</u> to <u>4-17-62</u> and last saw him alive on <u>4-16-62</u> Death occurred at <u>5 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>4-18-62</u>	
22a. SIGNATURE <u>Albert L. Carlson MD</u>		22b. ADDRESS <u>Stanherry, MO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>April 19 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandview</u>	23d. LOCATION (City, town, or county) (State) <u>Albany, Missouri</u>
24. FUNERAL DIRECTOR <u>Brooks-Cochell Funeral Home Albany, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-19-62</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. L. W. Bare</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/5910380203803456789540010111290-013 1-0

MAY 3 1962

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 Donald E. Coehel

Licensed Embalmer No. 4868
P. O. Address Albany, Mo.

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.