

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42223**

FILED DEC 27 1949

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6074 Registrar's No. 440

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST. FRANCIS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>DESLOGE</u>		c. LENGTH OF STAY (in this place) <u>1</u> 20 years	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>103 School STREET</u>		d. STREET ADDRESS (If rural, give location) <u>103 School</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Walter</u> b. (Middle) <u>NEWTON</u> c. (Last) <u>Pigg</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 9 1949</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov. 11, 1894</u>
9. AGE (in years last birthday) <u>75</u> Months <u>0</u> Days <u>28</u> Hours <u>0</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <u>Monitor Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Public</u>		11. BIRTHPLACE (State of foreign country) <u>Bonne Terre, R.R. 1</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wm C. Pigg</u>	
13b. MOTHER'S MAIDEN NAME <u>SARAH GRIFFEN</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Etta Pigg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-03-5685</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Etta Pigg</u>		ADDRESS <u>Desloge Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES: Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>unknown</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>3132x</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)			
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 <u>Feb 3, 1949</u> , to <u>12-9-</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>12-8-</u> , 19 <u>49</u> , and that death occurred at <u>2 P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Byron Taylor</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>Flat River, Mo.</u>	
23c. DATE SIGNED <u>12-10-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12-11-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Pigg Family Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Farmington R.R. 2, MO</u>	
DATE REC'D BY LOCAL REG <u>Dec. 13, 1949</u>		REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>	
FUNERAL DIRECTOR'S SIGNATURE <u>Boyer &amp; Son</u>		ADDRESS <u>Desloge MO</u>	

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

12-19-49

Health Officer No. 4  
License Number: 1249-1661

Date filed: \_\_\_\_\_

**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 .....  
Student Embalmer

Signed C. Z. Boyer

Licensed Embalmer No. 1671

P. O. Address Des Moines, 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 this body is not embalmed, fact should be so stated above.