

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Pike

Registration District No. 689

Township

Primary Registration District No. 3033

City Louisiana

(No. 221 224)

File No. 25935

Registered No.

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 321 224 St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lulu Irvine Pledge

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-13-47

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 7 4 4

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callaway, Mo

13. NAME Theo Gray Pledge

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) va

15. MAIDEN NAME Florence Leeper

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) va

17. INFORMANT (ADDRESS) Pledge Clarksville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Osua Mo DATE 7/22

19. UNDERTAKER (ADDRESS) Stacy's Pharmacy Louisiana Mo

20. FILED 7 20 1934 J. O. Navy Registrar

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-19 1934

22. I HEREBY CERTIFY, That I attended deceased from July 1 1934 to 7-19 1934

I last saw him alive on 7-19 1934 Death is said

to have occurred on the date stated above, at 10¹⁵ m.

The principal cause of death and related causes of importance were as follows:

Mercuric Poisoning Date of onset 10 days
131
132B

Other contributory causes of importance:
Breight's Disease 1 1/2 yrs

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. M. Pearson, M. D.

(Address) Louisiana Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 15 1934

A. Pearson

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

E. T. McLaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

Pike

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *R. W. Pledge*
Who died at _____ on *July 19 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *m* Color or race *w* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *87* Months *4* Days *4*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) *Wesley, Missouri*

Birthplace of father (State or country) _____

Birthplace of mother (State or country) *Wright's disease (chronic)*

Principal cause of death: _____

Other contributory causes of importance _____ *131*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar *E. T. McLaugh* Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *689*

Very truly yours,
E. T. McLaugh M.D.
E. C.

Primary Reg. Dist. No. *3033*

Special Agent.

MEMORANDUM FOR THE DIRECTOR

DATE: 10/15/54

TO: SAC, NEW YORK

RE: [Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

5-25935

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