

No. 2  
11-10-39  
5-1  
1

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1002

State File No. **14033**  
Registrar's No. **1745**

**MAY 15 1940** 399

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL," and name of township)  
(c) Name of hospital or institution: Reid Hotel **2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 10 Yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. Reid Hotel 10th. Broadway  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24  
year 1940 hour 6.30 minute 0 A. M.  
21. I hereby certify that I attended the deceased from April 1  
1940, to April 24, 1940  
that I last saw him alive on April 24, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Endocarditis **24**  
Due to \_\_\_\_\_ **days**  
Influenza **6**  
Due to \_\_\_\_\_ **was**  
Other conditions **11/0**  
(Include pregnancy within 3 months of death)

Duration  
**24**  
**days**  
**6**  
**was**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations none  
Of autopsy none

22. If death was due to external causes, fill in the following: none  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (f) Means of injury 1200  
23. Signature Walter B. Pugh (M. D. or other)  
\*Address Walter B. Pugh Date signed 4-24-40

3. (a) PRINT FULL NAME Burton H. Pugh **200**  
3. (b) If veteran, name war No 3. (c) Social Security No. no

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Belle Pugh 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased Febr. 2 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 2 21 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Topeka Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Publisher

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Robt. Pugh Ind.  
18. Birthplace Logansport Ind.  
(City, town, or county) (State or foreign country)  
14. Maiden name Susan Troutman  
15. Birthplace Logansport Ind.  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address Mrs B. H. Pugh Topeka  
17. (a) Burial (b) Date thereof 4 26 40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Topeka Kansas

18. (a) Signature of funeral director Eylar Funeral Home  
(b) Address 1800 Linwood Kc. C. Mo.  
19. (a) 4-24-40 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Chayer Elliott Elliot*

Licensed Embalmer No.....

*3054*

P. O. Address.....

*SA 1800 Linn*

**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, above space should be left blank.**