

Registration District No. 1160

Primary Registration District No. 4388

Registrar's No. 59

1160 JUL 15 1940

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Caruthersville
(c) Name of hospital or institution: 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 11 months years, months or days

3. (a) PRINT FULL NAME A. Jack Pugh

3. (b) If veteran, name war _____ (c) Social Security No. None

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jula Pugh 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Dyers Co. Tenn (City, town, or county) (State or foreign country)

10. Usual occupation Labour

11. Industry or business Common Labor

MOTHER FATHER { 12. Name unknown

13. Birthplace _____ (City, town or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Tommy Pugh

(b) Address Caruthersville Mo.

17. (a) Burial (b) Date thereof 6-20-40 (c) Place: burial or cremation Morgan Ridge entry 585

18. (a) Signature of funeral director H. P. Smith

(b) Address Caruthersville Mo.

19. June 19, 1940 (b) C. de Montis (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
(c) City or town Caruthersville Mo.

(If outside city or town limits, write "RURAL")

(d) Street No. E 12th St. (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 19 year 1940 hour _____ minute 9 A M.

21. I hereby certify that I attended the deceased from May 18 - 1940 to June 19, 1940 that I last saw him alive on May 18 - 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Valvular Heart Disease Duration 2 yrs.

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(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? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. B. Linton (M. D. or other) _____

Address Caruthersville, Mo. Date signed 6-19-40

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

7-40-23

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22465-
Registrar's No. 59

Registration District No. 651

Primary Registration District No. 4388

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

1. PLACE OF DEATH:

(a) County Peru

(b) City or town Cynthiana
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME A. Unknown Jack Pugh

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race B

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

20. DATE OF DEATH Month 6 day 19
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that I last saw him _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Oct. 4, 1940 (b) Ada Martin
(Date received local registrar) (Registrar's signature)

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(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? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

