

STANDARD CERTIFICATE OF DEATH

Registration District No. 249

Primary Registration District No. 4149

Registrar's No.

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Coifey  
(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 one week  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Elzy Pugh

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 500-02-1412

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dorothy 6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased Jan 14 1904  
(Month) (Day) (Year)

8. AGE: Years 36 Months 8 Days 26 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Daviess Co Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business any kind

12. Name Malis Pugh

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

14. Maiden name Nancu Cray

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

16. (a) Informant Dorothy Pugh

(b) Address Coifey Mo.

17. (a) burial (b) Date thereof 10-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jameson Mo.

18. (a) Signature of funeral director [Signature]  
(b) Address Gallatin Mo.

19. (a) Oct. 10 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Daviess  
(c) City or town Jameson Rural  
(If outside city or town limit write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10  
year 1940 hour 3pm minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 9-22-40  
\_\_\_\_\_ 19\_\_\_\_, to 10-9-40 \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on 10-9-40 \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Aortic insufficiency

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Jameson Mo. Date signed \_\_\_\_\_

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

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**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.....

*E. M. Jordan*

Licensed Embalmer No. *3453*

P. O. Address *Fall River 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, above space should be left blank.**