No. 2
1-4-41
-17-39
X25390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15789

Registration District No. 784 Primary Registration District No. 20 Registrar's No. 947

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 MONTHS (Specify whether years, months or days)

In this community ~~5 MONTHS~~

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 508 Walton
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME DORA BUGG

3. (b) If veteran, name war none.

3. (c) Social Security No. 492-01-1145

4. Sex F 1

5. Color or race W

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

6. (b) Name of husband or wife HAROLD E. BUGG

6. (c) Age of husband or wife if alive? 34 years

7. Birth date of deceased November (Month) 28 (Day) 1911 (Year)

8. AGE: Years 29 Months 5 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace De Soto (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Milliner

11. Industry or business

FATHER 12. Name John Roberts

13. Birthplace De Soto (City, town, or county) Mo. (State or foreign country)

MOTHER 14. Maiden name Fleta Windes

15. Birthplace Rush Tower (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Koch Hospital Record.

(b) Address St Louis Co., Mo.

17. (a) Burial - (Burial, cremation, or removal) (b) Date thereof 5-7-1941 (Month) (Day) (Year)

(c) Place: burial or cremation New Picker Cem.

18. (a) Signature of funeral director C. R. Lupton + Sons.

(b) Address #7233 Delmar Blvd.

19. (a) MAY - 9 1941 (Date received local registrar) (b) C. R. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th. year 1941 hour 9 minute 25 P.M.

21. I hereby certify that I attended the deceased from November 11, 1940 to May 4th 1941; that I last saw her alive on May 4th 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	1 year
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Paul Murphy (M. D. or ~~other~~)

Address Robert Koch Hospital Date signed 5-5-41

(Licensed Embalmer's Statement on Reverse Side)

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. Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address. St Louis M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.