2
41
39
26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31345

Registration District No. 191 Primary Registration District No. 5 2 6 Registrar's No.

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Luray - Rural.
(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 2 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clark

(c) City or town Luray - Rural.
(If outside city or town limits, write "RURAL")

(d) Street No. 23
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frank Pugh.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Docia Pugh.

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

7. Birth date of deceased Oct. 22 - 1881
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
59	9	29	hr. min.

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

10. Usual occupation Farming.

11. Industry or business

FATHER
12. Name Oliver Pugh.
13. Birthplace N.C.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Hester Sasseen
15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Docia Pugh.
(b) Address Luray Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23 - 1941
(Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Richland Iowa

18. (a) Signature of funeral director Guttrig, Ind.
(b) Address Kahoka Mo.

19. (a) Oct 3 - 1941 (Date received local registrar) (b) Otis L Guttrig (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21
year 1941 hour 11 minute 50 A.M.

21. I hereby certify that I attended the deceased from 1939
19 to August 21 1941
that I last saw him alive on August 21 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to

Due to 93d

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 Lawrence E. Lowe (M.D. or other) Do
Address Luray Mo. Date signed

115 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-41-1825
Date Filed OCT 13 1941

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 Otis L. Sutting

Licensed Embalmer No. 2965

P. O. Address Leroy Mo

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

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

No. 2B
8-21-41
X29288

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. 31345

Registration District No. 191 Primary Registration District No. 5266 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Clark

(b) City or town: Luray
(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 years, months or days)

In this community: 2 yrs

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Frank Pugh

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife: Dorcia Pugh

6. (c) Age of husband or wife if alive: 48 years

7. Birth date of deceased: Oct (Month) 22 (Day) 1882 (Year)

8. AGE: Years 59 Months 9 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1941 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.

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

5-31345 1941