

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006946

STATE FILE NUMBER
2 1537

FILED MAR 2 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. City Hosp</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>4244 Washington</i>
3. NAME OF DECEASED (Type or print) <i>Lee Auther Bugg</i>		4. DATE OF DEATH <i>Feb. 10 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/15/1917</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE (In years last birthday) <i>41</i>
13a. FATHER'S NAME <i>Lee Auther Bugg</i>		13b. MOTHER'S MAIDEN NAME <i>Belle Fox</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. _____	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suffocation</i>		14. NAME OF HUSBAND OR WIFE _____	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____		17. INFORMANT <i>Lee Auther Bugg 4244 Washington</i>	
DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		934.046	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. INJURY OCCURRED (Enter only one injury in PART II) <i>Asphyxiated in area above by squads on February 10th 1959</i>		
20c. TIME OF INJURY Hour <i>2:00</i> a.m. Month, Day, Year <i>2 10 59</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <i>1924</i>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <i>St. Louis Mo</i>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____		22a. ADDRESS <i>1300 Clark</i>	
22b. SIGNATURE (Degree or title) <i>Opal</i>		22c. DATE SIGNED <i>2/13/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>13 Feb. 1959</i>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <i>Tapele, Mississippi</i>
24. FUNERAL DIRECTOR ADDRESS <i>Reliable Funeral Sys. 1389N. Union</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 13 59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John K Cunningham*
Licensed Embalmer No. *4476*
P. O. Address *2405 Marcu*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.