

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

33552  
52652

**1. PLACE OF DEATH**

County Harrison Registration District No. 334  
 Township Bethany Primary Registration District No. 4197  
 City Bethany (Name) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Courtley Marion Pugh

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Y

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-24-1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 0 14

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Harrison Co Mo

10. NAME OF FATHER Guy Vernon Pugh

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Harrison Co Mo

12. MAIDEN NAME OF MOTHER Ida Wilson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Harrison Co Mo

14. INFORMANT (Address) Guy V Pugh  
Bethany Mo

15. FILED 11/9 1929 W J Harwood REGISTRAR

**3**

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-8 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 to Oct 9 1929  
 that I last saw h. alive on Oct 8, 1929, and that death occurred, on the date stated above, at 3 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Nephritis  
130  
104 A  
134 B (duration) yrs. mos. 14 da.

**CONTRIBUTORY**

(SECONDARY) (duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

Did an operation precede death: \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY: \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS: \_\_\_\_\_

(Signed) E. M. Purpitt, M.D.  
10-8-29 (Address) Bethany Mo

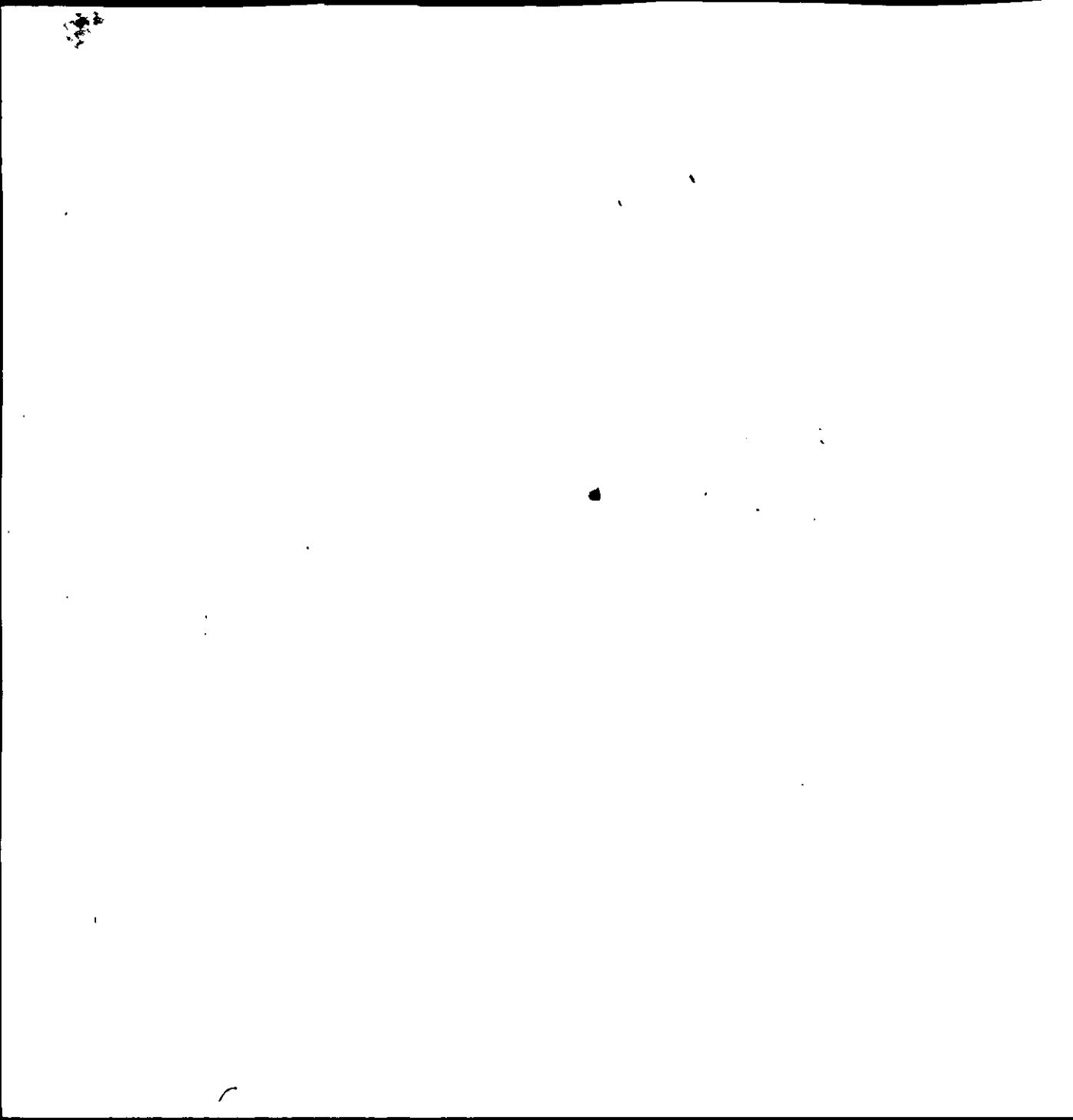
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Gravie Chapel 10-8 1929

20. UNDERTAKER ADDRESS

S. W. Haas Bethany Mo



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Harrison Registration District No. 334 File No. 926  
Township Palmer Primary Registration District No. 4197 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

Cartley Marion Deugh  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT \_\_\_\_\_  
(Address) \_\_\_\_\_

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_  
M. H. Harned  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 8 - 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_  
19 \_\_\_\_\_ to \_\_\_\_\_, 19 \_\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_, and that  
death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

acute nephritis  
acquired following  
flu (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 19 \_\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

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