

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39249

State File No. _____

Registration District No. 13

Primary Registration District No. 3010

Registrar's No. 138

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Carrollton
(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 _____
years, months or days

8. (a) PRINT FULL NAME John Bugh
 8. (b) If veteran _____ (c) Social Security No. _____
 name war _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Martha Chief 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 17 1853
(Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Mrs Mitten
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ben Bugh
 (b) Address Carrollton Mo

17. (a) _____ (b) Date thereof Nov 19 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Church Cem

18. (a) Signature of funeral director Milton Standby

(b) Address Carrollton Mo

19. (a) 11-18-39 (b) Peth Haskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
 (c) City or town Carrollton
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 18
 year 1939 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from 10-1-39
 _____, 19____, to 11-18, 1939
 that I last saw him alive on 11/17/39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Uraemia
 Due to Chc nephritis
 Due to General arteriosclerosis
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations 121
 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? _____

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature P. B. Drown (M. D. or other) M.D.
 Address Carrollton Mo Date signed 11/18/39

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12/6/39

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 Norman S. Becker
Licensed Embalmer No. 4057
P. O. Address Carrollton, 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.