

FILED AUG 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22952

State File No.

BIRTH NO. _____ REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 5371 Registrar's No. 73

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

1. PLACE OF DEATH a. COUNTY <u>Daviness</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Daviness</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>"Rural" Washington</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jameson</u>	
c. LENGTH OF STAY (in this place) <u>2 mons.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3</u>		STREET ADDRESS (If rural, give location) <u>6</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ida</u>	b. (Middle) <u>Pugh</u>	c. (Last) <u>Pugh</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 28 1949</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 2, 1862</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>5</u>	IF UNDER 24 HRS. Hours <u>7</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Richmond, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William H. Turner</u>	13b. MOTHER'S MAIDEN NAME <u>Eliza Jane Harrah</u>	14. NAME OF HUSBAND OR WIFE <u>Willie Pugh</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Ottie Bennett, Orleans, Neb.</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculous meningitis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>		<u>7/20X</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 27, 1949, to July 28, 1949, that I last saw the deceased alive on July 27, 1949, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

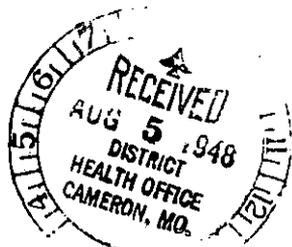
23a. SIGNATURE (Degree or title) <u>J. B. Bailey M.D.</u>	23b. ADDRESS <u>Camport, Mo.</u>	23c. DATE SIGNED <u>8-2-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 31, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Scotland Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>"Rural" Daviness county, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>4 Aug 1949</u>	REGISTRAR'S SIGNATURE <u>Vergenia M Engelbach</u>	5. FUNERAL DIRECTOR'S SIGNATURE <u>Hope Funeral Home</u>	ADDRESS <u>Gallatin, Mo.</u>
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Terma R Hope

AUG 31 1949



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
Student Embalmer

Signed Lenna F. Hoffe

Licensed Embalmer No. 2162

P. O. Address _____

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, fact should be so stated above.