FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23594

BIRTH NO. 42231-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3215

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

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 3233 Anderson

3. NAME OF DECEASED (Type or Print)
a. (First): Danny
b. (Middle): Bruce
c. (Last): Pugh

4. DATE OF DEATH (Month) (Day) (Year): 7-18-1949

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: 7-17-1949
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days: 1 — IF UNDER 24 HRS. Hours / Min.: 39 / 52

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Harold Ernest Pugh
13b. MOTHER'S MAIDEN NAME: Betty Ruth Reeves
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Mrs. H. E. Pugh
ADDRESS: 3233 Anderson K.C. Mo.

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia neonatorum — INTERVAL BETWEEN ONSET AND DEATH: 46 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Abnormally short & stormy labor
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
7620
20. AUTOPSY? YES ☒ NO ☐

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-17, 1949, *to* 7-18, 1949, *that I last saw the deceased alive on* 7-18, 1949, *and that death occurred at* 5:40 p m., *from the causes and on the date stated above.*

23a. SIGNATURE K. E. Cox (Degree or title): MD
23b. ADDRESS: 320 W 47th
23c. DATE SIGNED: 20 July '49

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 7-18-1949
24c. NAME OF CEMETERY OR CREMATORY: St Luke's Hospital
24d. LOCATION (City, town, or county) (State): Kansas City, Mo

DATE REC'D BY LOCAL REG.: 7-25-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: St Luke's Hosp. K.C. Mo.
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.