

FILED JAN 12 1956

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

41301

State File No.

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 37

1. PLACE OF DEATH
a. COUNTY Livingston.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. CITY Ray

b. CITY (If outside corporate limits, write RURAL and give township)
Chillicothe

c. LENGTH OF STAY (in this place)
14 days

c. CITY OR TOWN Braymer

d. Is Residence within limits of a city or incorporated town?
Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Chillicothe Hosp

e. STREET ADDRESS (If rural, give location)
Grape Grove Twn.

3. NAME OF DECEASED
a. (First) Wade b. (Middle) Hampton c. (Last) PUGH

4. DATE OF DEATH
(Month) (Day) (Year)
Dec. 30, 1955

5. SEX
male

6. COLOR OR RACE
white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
widow

8. DATE OF BIRTH
Aug. 9, 1869

9. AGE (in years last birthday)
86yrs

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer, retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country)
Ray County Missouri

12. CITIZEN OF WHAT COUNTRY?
U.S.

13a. FATHER'S NAME
Samuel Pugh

13b. MOTHER'S MAIDEN NAME
Alice Wall

14. NAME OF HUSBAND OR WIFE
deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.
no ne

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs Leona Rogers Braymer, 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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asymptomatic Pneumonia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Embolism
DUE TO (c) Cholelithiasis acute.
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
585x

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
12/10/55

19b. MAJOR FINDINGS OF OPERATION
Acute Hemorrhagic Cholelithiasis

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)

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 Oct 27, 1955 to Dec 30, 1955, that I last saw the deceased alive on 12/30/55, and that death occurred at 9:30a from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
J. M. Arnold MD

23b. ADDRESS
Chillicothe, Mo

23c. DATE SIGNED
1-2-56

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE
1-1-56

24c. NAME OF CEMETERY OR CREMATORY
New Hope Cem.

24d. LOCATION (City, town, or county) (State)
Braymer, Mo.

DATE REC'D BY LOCAL REG.
1-2-56

REGISTRAR'S SIGNATURE
Francis B. Neill

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Mead Funeral Service, B.F.M. Braymer, Mo

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

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

Barnd L. Mead

Licensed Embalmer No. 2801

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