

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032481

STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 141

Primary Registration District No. 3085

Registrar's No. 62

3  
S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>HOWELL</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BOONE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEST PLAINS</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>COLUMBIA</b> <i>0105</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HO. CO. FAIR GROUNDS</b>		Length of stay in 1b	d. STREET ADDRESS <b>1308 BASS</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EDWARD</b> Last <b>PUGH</b>			4. DATE OF DEATH Month <b>SEPT</b> Day <b>4</b> Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 26, 1915</b>		9. AGE (In years last birthday) <b>42</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ANIMAL HUSBANDRY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STATE UNIVERSITY</b>	11. BIRTHPLACE (City and state or country) <b>MT. VERNON, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>EARL W. PUGH</b>		13b. MOTHER'S MAIDEN NAME <b>MARY JOHNSON</b>		14. NAME OF HUSBAND OR WIFE <b>SUE PUGH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or years of service)		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT <b>LARRY MCCANSE</b> Address <b>WEST PLAINS, MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>4201</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <b>9</b> Month, Day, Year <b>9-4-58</b> p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HO CO FAIR GROUNDS</b>		20f. CITY, TOWN, OR LOCATION <b>WEST PLAINS,</b> COUNTY <b>HOWELL</b> STATE <b>MO.</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Joe C. Duncan</i> (Degree or title) <b>3</b>			22b. ADDRESS <b>Mtn. View, Mo.</b>		22c. DATE SIGNED <b>9-22-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>9-4-58</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>COLUMBIA, MISSOURI</b>
24. FUNERAL DIRECTOR <b>ROBERTSON</b> ADDRESS <b>WEST PLAINS, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>9-26-58</b>		26. REGISTRAR'S SIGNATURE <i>Beatrice Cook</i>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

SEP 29 1958

APR 30 1959

APR 15 1959

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 [Handwritten Signature] Licensed Embalmer No. 4577 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.