

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040310

FILED VS NOV 23 1959

189

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

5374

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>JACKSON</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>31 YRS.</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WALNUT NURSING HOME</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4036 EAST 69TH TERR.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>FRANKLIN</u> Last <u>PUGH</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>6</u> Year <u>1959</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8/21/1890</u>		9. AGE (last birthday) <u>69</u>	
10a. USUAL OCCUPATION (Give kind of work done during previous 12 months, even if retired) <u>MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHINERY</u>		11. BIRTHPLACE (City and state or country) <u>NEVADA, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>WILLIAM PUGH</u>			13b. MOTHER'S MAIDEN NAME <u>LULA AYLOR</u>			14. NAME OF HUSBAND OR WIFE <u>JULIA T. PUGH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>496-16-5735</u>		17. INFORMANT <u>ROBERT A. PUGH</u> <u>4036 E. 69TH TERR., K.C. MO.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Encephalomalacia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Brain Syndrome</u>								<u>7 mos</u>	
DUE TO (c) <u>Advanced Cerebral Arteriosclerosis - Unbroken</u>								<u>Unbroken</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.		Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>April 1959</u> to <u>11-6-59</u> and last saw <u>her</u> him alive on <u>11/4/59</u> . Death occurred at <u>7:25 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>P. Kenberger MD</u> (Degree or title)				22b. ADDRESS <u>5246 St John</u>				22c. DATE SIGNED <u>11/6/59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>NOV. 9, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>		23d. LOCATION (City, town, or county) <u>Kansas City Mo.</u>			
24. FUNERAL DIRECTOR <u>P. C. H. BLACKMAN & SON INC. K.C. Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>11-9-59</u>		26. REGISTRAR'S SIGNATURE <u>New Minshall</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Kenberger

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 Best B. Best

Licensed Embalmer No. 465

P. O. Address H. C. S

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.