

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044987

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. *149*

Primary Registration District No. *1002*

Registrar's No. *6391*

STATE FILE NUMBER

AMENDED

FILED JAN 8 1962

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Kansas</i> b. COUNTY <i>Johnson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		c. CITY OR TOWN <i>Shawnee Mission</i>	
Length of stay in 1b <i>3 Weeks</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 <i>Menorah Medical Center</i>		d. STREET ADDRESS (If outside, give location) <i>6611 Wenonga Terrace</i>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Alice G. Pugh</i>			4. DATE OF DEATH Month Day Year <i>12 10 61</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>3/4/76</i>
9. AGE (last birthday) <i>85 88</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) <i>Davies County, Mo.</i>
12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>		13a. FATHER'S NAME <i>James H. Grant</i>	
13b. MOTHER'S MAIDEN NAME ---		14. NAME OF HUSBAND OR WIFE <i>Everett Pugh</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs. Jack Bear</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of lt hip.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Generalized arteriosclerosis</i>		<i>10 yrs</i>	
DUE TO (c)			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>Fell on leaving church, down stone steps</i>	
20c. TIME OF INJURY Hour <i>12:30</i> Month, Day, Year <i>11/26/61</i> p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Church 5700 Outlook</i>	
20e. CITY, TOWN, OR LOCATION <i>mission</i>		COUNTY <i>Johnson</i> STATE <i>Ke</i>	
21. I attended the deceased from <i>11/26/61</i> to <i>12/19/61</i> and last saw her/him alive on <i>12/18/61</i> Death occurred at <i>1 A M</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. Meser M D</i>		22b. ADDRESS <i>mission Ke</i>	
22c. DATE SIGNED <i>12/19/61</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Dec. 21, 1961</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Grand River Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Jamison Missouri</i>
24. FUNERAL DIRECTOR <i>D. W. NEWCOMER'S SONS</i>		25. DATE RECD. BY LOCAL REG. <i>12-20-61</i>	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
ADDRESS <i>331 Brush Cr. KANSAS CITY MO</i>			

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. Meser

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 Kenneth W. Pearson

Licensed Embalmer No. 4889

P. O. Address Lathrop, 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.