

REC'D MAR 15 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

6626  
Do not use this space.

1. PLACE OF DEATH

(a) County Henry Registration District No. 349  
(b) Township Debo Primary Registration District No. 4207  
(c) City Calhoun (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

5311 William Scullage Mayhugh  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Addie May Mayhugh  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 3 1884  
7. AGE YEARS 55 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. Retired  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Beardsville Mo  
FATHER 13. NAME Richard Lurie Mayhugh  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Moniteau County Mo  
MOTHER 15. MAIDEN NAME Harnett Parker  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Benton County Mo  
17. INFORMANT (ADDRESS) Addie May Mayhugh  
Calhoun Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Andrew DATE Feb 5 1939  
19. FUNERAL DIRECTOR (ADDRESS) W. H. House  
Calhoun Mo  
20. FILED 2-7 1939 Ma. A. G. Gray  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 3 1939  
22. I HEREBY CERTIFY, That I attended deceased from Aug 28 1938 to Feb 3 1939  
I last saw him alive on Feb 3 1939 Death is said to have occurred on the date stated above, at 5 P. m.  
The principal cause of death and related causes of importance were as follows:  
Grand Paralysis  
Date of onset 10/28/1938  
Other contributory causes of importance: \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis?  Was there an autopsy? \_\_\_\_\_  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?  Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? Calhoun Mo (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) D. A. Ballard M. D.  
30 of (Address) Calhoun Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa.

82A

RECEIVED

District Health Officer No. 7,

District File Number 7-39-280

Date Filed 3-8-39

STATEMENT BY LICENSED EMBALMER

I J. A. Housey Licensed Embalmer No. 3502

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed J. A. Housey  
Licensed Embalmer No. \_\_\_\_\_

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

# MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

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### 1. PLACE OF DEATH

(a) County Henry Registration District No. 349  
(b) Township Calhoun Primary Registration District No. 4207  
(c) City Calhoun (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

### 2. PRINT FULL NAME

Wm Sculley Mayhugh  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

### PERSONAL AND STATISTICAL PARTICULARS

### MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-3-1929

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-3-1884

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 55

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

General Paralysis Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Cerebral Hemorrhage  
Other contributory causes of importance: seen that \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_, 19\_\_\_\_ Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) D. G. Pollard, M. D.  
(Address) Calhoun Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT

