

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 16 1941  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18412  
Registrar's No. 15

Registration District No. 558 Primary Registration District No. 5749

1. PLACE OF DEATH:  
(a) County Mercer  
(b) City or town Harrison S.W.  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community all his life years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Mercer  
(c) City or town Pinebluff Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. W.F.R. 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Wallace W Putman  
3. (b) If veteran, name war ✓ 3. (c) Social Security No. alt age  
4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 2 1856  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 25 year 1941 hour 1 minute P M.  
21. I hereby certify that I attended the deceased from April 16, 1941, to April 25, 1941;  
that I last saw him alive on April 24 and that death occurred on the date and hour stated above.  
Immediate cause of death Dementia Duration \_\_\_\_\_

8. AGE: Years 85 Months 0 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Mercer Co. Ohio  
(City, town, or county) (State or foreign country)

Due to Cardiac Hypertrophy and Atherosclerosis 3 yrs  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Farmer  
11. Industry or business \_\_\_\_\_  
12. Name Willard Putman  
13. Birthplace P. Y.  
(City, town, or county) (State or foreign country)  
14. Maiden name Francis Fairchild  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Elga Putman  
(b) Address Pinebluff Mo  
17. (a) Burial (b) Date thereof April 27-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Saint Paul  
18. (a) Signature of funeral director Paul Mason  
(b) Address Pinebluff Mo  
19. (a) 4/26-41 (b) J.M. Perry  
(Date registered local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature D. S. Duff (M. D. or other) \_\_\_\_\_  
Address Carnesville Mo Date signed 4/26/41

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 important.

9502

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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Neil Mason  
Licensed Embalmer No. 2684  
P. O. Address Clinton 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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18412

Registration District No. 558

Primary Registration District No. 5749

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Mercer  
(b) City or town Harrison Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Wallace W. Putman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 85 Months - Days 23  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 25 -  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Ulceric Poison *Dwajon*

Cardiac Hypertrophy

Due to Arterio Sclerosis

Due to Chronic Hypertension  
for 5 yrs standing

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature H. J. Duff (M. D. or other) \_\_\_\_\_

Address Carnsville, Mo Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

S-18412 1941