

FILED OCT 17 1944

Registration District No. 40

Primary Registration District No. 4051

Registrar's No.

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Hallsville
 (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 1 Year (Specify whether
 In this community 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone / 0
 (c) City or town Hallsville / 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME SAMUEL CUMMINS PUCKETT

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 2 - 24 - 1857
 (Month) (Day) (Year)

8. AGE: Years 87 Months 7 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace West Virginia
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name John Puckett
 13. Birthplace West Virginia
 (City, town, or county) (State or foreign country)
 14. Maiden name Ruth Birch
 15. Birthplace West Virginia
 (City, town, or county) (State or foreign country)

16. (a) Informant J.L. Puckett
 (b) Address Hallsville, Mo.

17. (a) Burial (b) Date thereof 10-9-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Red Top Cemetery

18. (a) Signature of funeral director Charan Funeral Service
 (b) Address Columbia, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7
 year 1944 hour 5 minute _____ A.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 _____ Duration _____
Cardiac Decompensation
 Due to acute Pulmonary congestion
Sclerosis & Thrombosis

Other conditions (Include pregnancy within 3 months of death) 95C2

Major findings: Of operations _____
 Of autopsy as above

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? _____

(Specify type of place) While at work _____ (e) Means of injury _____

23. Signature Thomas McElaine (M.D. or other) _____
 Address Hallsville, Missouri Date signed 10/9-44

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

1243

8757-5412

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, fact should be so stated above.

Registration District No. HO

Primary Registration District No. 4051

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Hallsville
(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 Samuel C. Buckate

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m **5. Color or** w **6. (a) Single, widowed, married,** w
divorced, w

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased Feb. 24, 1951
(Month) (Day) (Year)

8. AGE: Years 87 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation Retired farmer

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** Oct 9, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hallsville, Mo.

18. (a) Signature of funeral director Barbers

(b) Address Columbia

19. (a) Nov. 4, 1944 **(b)** Mrs. Leon Burbey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Boone

(c) City or town Hallsville
(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 Oct Day 9 Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ **Date signed** _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

33694