

**FILED JUN 14 1945**

Registration District No. **339**

Primary Registration District No. **6149**

Registrar's No. **8**

1. PLACE OF DEATH:

(a) County **Stoddard**  
(b) City or town **Rural N. Stoddard**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1 Hosp**  
(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)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME **John F. Pillow,**

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

20. DATE OF DEATH: Month **May** day **30**  
year **1945** hour **9** A.M. minute..... M.

21. I hereby certify that I attended the deceased from **May 24** 1945 to **May 30** 1945;  
that I last saw him alive on **May 29** 1945;  
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Anna** 6. (c) Age of husband or wife if alive **1886** years

Immediate cause of death  
**Acute Congestive heart failure**  
Due to **Cardiac hypertrophy**  
Due to **Aortic stenosis**

7. Birth date of deceased **June 24** (Month) (Day) (Year)  
8. AGE: Years **59** Months **11** Days **6** If less than one day hr. min.

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

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **Un Known**  
13. Birthplace **Un known** (City, town, or county) (State or foreign country)  
14. Maiden name **Un Known**  
15. Birthplace **Un Known** (City, town, or county) (State or foreign country)

Other conditions (Includes pregnancy within 3 months of death)  
Major findings: Of operations **9.22**  
Of autopsy  
PHYSICIAN Underline the cause to which death should be charged statistically.

16. (a) Informant **anna Pillow**  
(b) Address **Puxico Missouri,**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
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?

17. (a) **Burial** (b) Date thereof **June 1 1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Moleansboro IA**

18. (a) Signature of funeral director **Watkins Service**  
(b) Address **Puxico Missouri**

(Specify type of place)  
While at work? (c) Means of injury.....  
23. Signature **H. Skellings** (M. D. or other) **Do**  
Address **Puxico** Date signed **5/30/45**

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

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

MOTHER, FATHER

RECEIVED

Office No. 7

District File Number

Date Filed

645-80  
6-6-45

BIAC BI

**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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Rayman Steele*

Licensed Embalmer No.

2476

P. O. Address

*Alexander, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June  
Registrar's No. 8

Registration District No. 339

Primary Registration District No. 6149

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Prue  
(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

John F. Pullen

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 m

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

7. Birth date of deceased June 24 (Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ 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) 5-30-1945 (b) J. Steiner (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 June year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

LACK INK—MAKE A PERMANENT RECORD

WRITE PLAINLY—USE UNFAD

183916