

No. 2
M-5-43
7-5-17-39
X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
UNITED STATES STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13354
1580
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town KANSAS CITY
(c) Name of hospital or institution: ST JOSEPH'S HOSPITAL
(d) Length of stay: In hospital or institution 12 DAYS
In this community 12 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town CARTHAGE
(d) Street No. _____
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME ALMA PUTMAN SCHLECHT
(b) If veteran, name war NO
(c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month APRIL day 1st
year 1946 hour 7 minute 35 P. M.
21. I hereby certify that I attended the deceased from march 15th 1946 to April 1st 1946
that I last saw her alive on April 1st 1946
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
(b) Name of husband or wife Dr. JOHNN A. SCHLECHT
(c) Age of husband or wife if alive 65 years
7. Birth date of deceased: SEPT. 23 1881

Immediate cause of death: Embolism to left middle cerebral artery
Due to: Mural Thrombus left mitral valve
Other conditions: Upper Right lobe Bronchiectasis

8. AGE: Years 58 Months 6 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace: CLINTON, MISSOURI

10. Usual occupation: HOUSE WIFE

11. Industry or business: WALTER PUTMAN

12. Name: WALTER PUTMAN

13. Birthplace: UNKNOWN ILLINOIS

14. Maiden name: SARAH HARRISON

15. Birthplace: UNKNOWN ILLINOIS

16. (a) Informant: Dr. John J. Schlecht

(b) Address: Carthage Mo

17. (a) Cremation (b) Date thereof: APRIL 2 1946

(c) Place: burial or cremation: D. W. NEWCOMER'S SONS

18. (a) Signature of funeral director: D. W. Newcomer

(b) Address: 1401 Branch Creek TC Mo

19. (a) 4-2-46 (b) Geraldine Holmes

Other conditions: Upper Right lobe Bronchiectasis
Major findings: 92-6
Of operations: _____
Of autopsy: abuse funeral

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
23. Signature: [Signature] (M. D. or other) _____
Address: TC Mo Date signed: 4-2-46

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

MOTHER FATHER

MAY 20 1946

12 15

MAY 21 1946

JUL 1 1947

JUN 18 1947

JUN 10 1948

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 Paul Gapp

Licensed Embalmer No. 3458

P. O. Address. K.C. 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.