

FILED OCT 16 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. 3.7

Primary Registration District No. 6076

Registrar's No. 2069

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ROBERT KOCH HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 312 days
 (Specify whether
 In this community 26 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1003 N. GARRISON
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME PUTTMAN, ROSE MAE
 3. (b) If veteran, name war no
 3. (c) Social Security No. 45-18-3688

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 10 day 1
 year 46 hour 8 minute 00 A.M.
 21. I hereby certify that I attended the deceased from JUNE 13, 1946, to OCT-1-, 1946
 that I last saw her alive on OCT-1-, 1946
 and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race colored
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death _____
Pulmonary tuberculosis 2 years

7. Birth date of deceased: 12 - 12 - 12
 (Month) (Day) (Year)
 8. AGE: Years 33 Months 9 Days 30
 If less than one day _____ hr. _____ min.

Duration _____
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy no

9. Birthplace HAZEL HURST MISS.
 (City, town, or county) (State or foreign country)
 10. Usual occupation FOOD HANDLER

PHYSICIAN
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 12. Name STEPHEN PUTTMAN
 13. Birthplace 2 9
 (City, town, or county) (State or foreign country)
 14. Maiden name ROSABELL MONTGOMERY
 15. Birthplace 2 9
 (City, town, or county) (State or foreign country)

16. (a) Informant KOCH HOSPITAL RECORD
 (b) Address KOCH MO
 17. (a) Burial (b) Date thereof 10-7-46
 (burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park

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 _____
 Signature [Signature] (M. D. or other) MD
 Address KOCH MO Date signed 10-1-46

18. (a) Signature of funeral director [Signature]
 (b) Address 1003 N. Garrison
 19. (a) 10-8-46 (b) Ruth E. Allen MO
 (Date received local registrar) (Registrar's signature)

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 *Arthur L. Halliard*

Licensed Embalmer No. *4226*

P. O. Address *1104 Bayard*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2069

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Rural
(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 Puttman, R. Mae
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased see 2
(Month) _____ (Day) _____ (Year) _____

8. AGE: Years 33 Months 9 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-8-46 (Date received local registrar) (b) Ruth J. Allen M.D. (Registrar's signature) 2052

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 CERTIFICATE FROM

20. DATE OF DEATH: Month _____ Day _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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

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

34835