

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009613

STATE FILE NUMBER

1403

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1403

1. PLACE OF DEATH  
a. COUNTY Jackson  
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City Inside Limits Yes  No   
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Length of stay in lb 2 hrs.  
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Missouri b. COUNTY Clay  
c. CITY OR TOWN Kansas City Inside Limits Yes  No   
d. STREET ADDRESS 5701 North Oak Reside on Farm Yes  No

3. NAME OF DECEASED First Infant Middle Putnam Last Putnam  
4. DATE OF DEATH Month 3 Day 14 Year 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED   
8. DATE OF BIRTH 3-14-1959 9. AGE (In years last birthday) 0 IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 2 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 10b. KIND OF BUSINESS OR INDUSTRY Infant 11. BIRTHPLACE (City and state or country) Kansas City, Missouri 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Robert O. Putnam 13b. MOTHER'S MAIDEN NAME Colleen Robinson 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Robert O. Putnam Address 5701 N. Oak K.C. Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Anemia  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pneumonia  
DUE TO (c) Incompetent cerebral or in mother  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7699  
INTERVAL BETWEEN ONSET AND DEATH  
19. WAS AUTOPSY PERFORMED? YES  NO

20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3-14-59 to 3-14-59 and last saw her/him alive on 3-14-59  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. Kermit Knoch MD (Degree or title) 22b. ADDRESS 4670 Webster St. K.C. Mo. 22c. DATE SIGNED 3-17-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 3-18-1959 23c. NAME OF CEMETERY OR CREMATORY - 23d. LOCATION (City, town, or county) (State) Lucerne, Missouri

24. FUNERAL DIRECTOR Melody-McGilley-Eylar ADDRESS Linwood & Main 25. DATE RECD. BY LOCAL REG. 3-17-59 26. REGISTRAR'S SIGNATURE Irlva Marshall

Health, Welfare, Public Service  
300  
-57  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
H. Kermit Knoch  
All diseases in Part I must be causally related.

*Dr. H. H. ...*

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Wm H. Gentry* .....

Licensed Embalmer No. *05038* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.