

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034020

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8184**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 22 1963

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

1	2	3	4	5	6	7	8	9	10	11	12	13
	21		1	2		1	2				74	

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>				Length of stay in. 1b <b>68 Years</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>530 N. Union Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES SPENCER PUTNAM</b>						4. DATE OF DEATH Month Day Year <b>August 10, 1963</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6/9/1888</b>		9. AGE (last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Bunker Hill, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>							
13a. FATHER'S NAME <b>Dr. E. L. Spencer</b>				13b. MOTHER'S MAIDEN NAME <b>Minnie Gimbel</b>				14. NAME OF HUSBAND OR WIFE <b>Lyman W. Putnam</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Florence S. Morris 530 N. Union Blvd.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <b>Branch Pneumonia</b>										<b>15 Day</b>					
DUE TO (b) <b>Myocardial failure</b>										<b>5 Days</b>					
DUE TO (c) <b>Ischemic Heart Disease. 420.0</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus, Thrombocytopenic Purpura et al.</b>										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year.				20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				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 <b>Jan 1963</b> to <b>8-10-63</b> and last saw her alive on <b>8-9-63</b> Death occurred at <b>5:15 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <b>Carl J. Peters M.D.</b> (Degree or title)						22b. ADDRESS <b>1825 Humphreys</b>				22c. DATE SIGNED <b>8-12-63</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/13/1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>		(State)							
24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 12 1963</b>		26. REGISTRAR'S SIGNATURE <b>Coal Smith. M.D.</b>									

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Carl J. Reis

18 S. Kingshighway

Fo. 1-0150

12:30 - 5P. M.

**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

*Vernon C. Vedder*

Licensed Embalmer No.

5031

P. O. Address

St. Louis, 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.