

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40676**

FILED DEC 12 1947

Registration District No. **581**

Primary Registration District No. **48755**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Sullivan**
(b) City or town **Milan**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **John William Pulliam**

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

4. Sex **male** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Daisy Pulliam** 6. (c) Age of husband or wife if alive **26** years
7. Birth date of deceased **Aug 24 69** (Month) (Day) (Year)

8. AGE: Years **78** Months **2** Days **28** If less than one day hr. min.

9. Birthplace **Linn Co Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

12. Name **Thos Pulliam**
13. Birthplace **don't know** (City, town, or county) (State or foreign country)
14. Maiden name **Lina Cassidy**
15. Birthplace **Linn Co Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Daisy B Pulliam**
(b) Address **Milan Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11/27-47** (Month) (Day) (Year)
(c) Place: burial or cremation **Reidin Mo Cem.**

18. (a) Signature of funeral director **Schauer**
(b) Address **Milan Mo**

19. (a) **Dec. 3-1947** (Date received local registrar) (b) **Mrs. H.B. Harris** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **24** year **1947** hour **9** minute **—** M.

21. I hereby certify that I attended the deceased from **Oct 2** 1947 to **Nov 24** 1947; that I last saw him alive on **Nov 24** 1947 and that death occurred on the date and hour stated above.

Immediate cause of death **Fatty Degeneration of heart**
Due to **angina pectoris**
attacked since last year

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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 **Q**

23. Signature **L. Grace Finamore** (M.D. or other) **RD**
Address **Milan Mo** Date signed **Nov 30**

Dec 1 1948

RECEIVED
District Health Officer No. 10
District File Number 12:47:1726
Date Filed DEC 1 0 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..... *Dwight Dehaene*
Licensed Embalmer No. *2667*
P. O. Address *Milan, 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.