

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36159
 Do not use this space.

NOV 23 1938

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 475
 (b) Township Spring River Primary Registration District No. 5639
 (c) City Verona (d) Street No. Verona General Hospital Registered No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. 6 wks (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

653 Mary Grace Puente
 (a) Residence, No. R. 2, Verona, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 7/38

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 month 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Verona, Mo.

FATHER 13. NAME Alois Joseph Puente
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Verona, Mo.

MOTHER 15. MAIDEN NAME Rose Catherine Tixik
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Verona, Mo.

17. INFORMANT (ADDRESS) Mr. Puente

18. BURIAL, CREMATION OR REMOVAL PLACE Catholic cemetery DATE Oct. 22, 1938
Verona, Mo.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wilks Funeral Home
Verona, Mo.

20. FILED 11/1 1938 A J Rudig
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 19, 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1938, to Oct. 19, 1938
 I last saw h. e. x. alive on Oct. 19, 1938. Death is said to have occurred on the date stated above, at 9 P. M.
 The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia Date of onset 10/18

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Dr. J. A. Watson, D. O.
 (Address) Verona, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1597

RECEIVED

District Health Officer No. 6,

District File Number 6-38-544

NOV 7 1938

Date Filed

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

36189

Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. _____
 (b) Township _____ Primary Registration District No. _____ Registered No. _____
 (c) City _____ (d) Street No. Verona Green Way St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME Mary G. Perreite

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 19 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Professional pneumonia Date of onset _____

as much as

and such disorders as

pneumonia, whooping

cough, etc. are not

shown on the face

Name of operation _____ Date of _____

What test or tests made? bleed (fluid) (Specify procedure)

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide _____ Date of injury _____ 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

was present or we

could have written it

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) F. A. Mataga

(Address) Verona Green Way

F. Avery

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT 10/19

