

No. 17-39 X21492

REC'D OCT 23 1940

Registration District No. 718

Primary Registration District No. 5947

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Putnam

(b) City or town Putnam - Union Twp

(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 2

In this community 1

years, months or days (Specify whether)

3. (a) PRINT FULL NAME Janet Sue Ransom

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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 June 8, 1939

(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 11

If less than one day hr. min.

9. Birthplace Union Twp Putnam Co Mo

(City, town, or county) (State or foreign country)

10. Usual occupation 0

11. Industry or business 0

MOTHER FATHER

12. Name William M. Ransome

13. Birthplace Putnam Mo

14. Maiden name Ethel Smith

15. Birthplace Lucerne Mo

(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Ransome

(b) Address Unionville Mo

17. (a) Burial (b) Date thereof Sept 25-14

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lucerne Mo

18. (a) Signature of funeral director

(b) Address Unionville Mo

19. (a) Sept 23, 1940 (b) W. W. Gilliam

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Putnam

(c) City or town Rural

(d) Street No. 0

(If rural, give location)

(e) If foreign born, how long in U. S. A. 1/2 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19

year 1940 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 19, 1940 to Sept 19, 1940

that I last saw her alive on Sept 19, 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Prothrombin

Duration 1 1/2 days

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?

645

(Specify type of place) While at work? (e) Means of injury

23. Signature J. K. W. Brown (M. D. or other)

Address Unionville Mo Date signed Sept 23, 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

109  
RECEIVED

District Health Officer No. 10, 1859

District File Number 10-40-1859

Date Filed OCT 8 1940

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 M. E. Kustel

Licensed Embalmer No. 3304

P. O. Address Unionville N.C.

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **32914**

Registration District No. **718**

Primary Registration District No. **5947**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Putnam**  
(b) City or town **Union Twp.**  
(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 \_\_\_\_\_ (Specify whether  
years, months, days)

3. (a) PRINT FULL NAME

**Janet Sue Casan**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 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 \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years **1** Months **3** Days **11** If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month **9** day **19** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_

23. Signature **E. T. W. Bigney** (M. D. or other) \_\_\_\_\_

Address **Unionville** \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2000