No. 2
M—2-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

32419

State File No.

FILED OCT 13 1943

Registration District No. 311 Primary Registration District No. 6054 Registrar's No. 11

93
0
0

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

1. PLACE OF DEATH:
(a) County St Clair
(b) City or town Rural Osage Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 10 Mi W of Rosco Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 46 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 93
(a) State Missouri (b) County St Clair 0
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 10 Mi W of Rosco Mo
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME James E. Puffenbarger
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of ~~husband or~~ wife Rose Puffenbarger
6. (c) Age of ~~husband or~~ wife if alive 66 years
7. Birth date of deceased 4-27-1867 (Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 14 If less than one day hr. min.

9. Birthplace Highland Co Mo 0 (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Jacob Puffenbarger
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Martha Mullinix
15. Birthplace Virginia (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Rose Puffenbarger
(b) Address Osceola Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 12 43 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Zion Cem
18. (a) Signature of funeral director Fred Wilkinson
(b) Address Clinton Mo
19. (a) Sept 15 1943 (Date received local registrar) (b) Dona M. Wells (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11 year 1943 hour 8 minute 15 P. M.
21. I hereby certify that I attended the deceased from July 1, 1940, to Sept 11, 1943 that I last saw him alive on Sept 9, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death urinic coma
Chronic nephritis

Due to Cystitis
Hypertrophied prostate

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature R. L. Hansen (M. D. or other) MD
Address Appleton City Mo Date signed 9-12-43

1338

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number 9-43-1037
Date Filed 10-11-43

## 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 Fred W Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton 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.**