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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7259

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. ~~290~~ 291

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County White 999
(c) City or town Mills Shoals 11
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 2
If yes, name country .....

3. (a) PRINT FULL NAME Clarence Puntney
3. (b) If veteran, name war Unknown
3. (c) Social Security No. 354-10-1929
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma C. Puntney
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased May (Month) 10 (Day) 1884 (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	8	28	..... hr. ..... min.

9. Birthplace White County (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation Laborer
11. Industry or business .....
FATHER
12. Name Robert W. Puntney
13. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown 9 (State or foreign country)
16. (a) Informant Emma C. Puntney 1
(b) Address Mills Shoals, Illinois
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/10/47 (Month) (Day) (Year)
(c) Place: burial or cremation Fairfield, Ill.
18. (a) Signature of funeral director Albert H. Hoppe, Inc
(b) Address 4700 Washington Blvd.,
19. (a) 2-10-47 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature) MA

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8 year 1947 hour ..... minute 7 45 A.M.
21. I hereby certify that I attended the deceased from 1-15, 1947 to Feb 8, 1947 that I last saw him alive on Feb 8, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon — Duration 6 mos
Due to .....
Due to 46 e
Other conditions Myocarditis, Chr
(Include pregnancy within 3 months of death)
Major findings: Of operations (Inoperable) Carcinoma of Colon
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) no
(b) Date of occurrence .....
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)
While at work? no (e) Means of injury 0
23. Signature Dr Duff Allen MD (M. D. or other)
Address 4500 Olive Street, Date signed 2-8-47

(Licensed Embalmer's Statement on Reverse Side)

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.....J. Allen Davis Jr

Licensed Embalmer No.....4053

P. O. Address.....St Louis

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.