

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

314

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 178

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Mo.</u>		c. LENGTH OF STAY (in this place) <u>2 Weeks</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>104 1/2 North 2nd Street</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>104 1/2 North 2nd St.</u>			d. STREET ADDRESS (If rural, give location) <u>104 1/2 North 2nd Street</u>		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>William</u>	b. (Middle)	c. (Last) <u>Puett</u>	(Month) <u>Febr.</u>	(Day) <u>8</u>	(Year) <u>1949</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Febr. 16 1896</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	--	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Common Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Craig Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	---	--

13a. FATHER'S NAME <u>Elizah Puett</u>	13b. MOTHER'S MAIDEN NAME <u>Ada Cook</u>	14. NAME OF HUSBAND OR WIFE <u>Unk.</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War 1&2</u>	16. SOCIAL SECURITY NO. <u>Unk</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Leo Drazkowski</u>	ADDRESS <u>Scottsbluff, Neb</u>
--	------------------------------------	--	---------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Oedema of the Lungs, and</u>		<u>2 weeks</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congestive Heart failure</u>		<u>2 weeks</u>
DUE TO (c) <u>Chronic Bronchial Asthma</u>		<u>3 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>man died suddenly while alone in his room at the Colonial Hotel.</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>He had been Complaining of shortness of breath, difficult breathing, nose bleed, and bronchitis</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) - (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I ^{attended} ~~attended~~ the deceased from 9:30 2/8, 1949, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:01 a.m., from the causes and on the date stated above. 3

23a. SIGNATURE (Degree or title) <u>H. F. Mundy M.D. (Coroner)</u>	23b. ADDRESS <u>404 No 3rd St.</u>	23c. DATE SIGNED <u>2-8-49</u>
--	------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2/9/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Scottsbluff Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Scottsbluff Nebr.</u>
--	---------------------------	--	--

DATE REC'D BY LOCAL REG. <u>Feb 10, 1949</u>	REGISTRAR'S SIGNATURE <u>E. G. Jenkins</u>	382 FUNERAL DIRECTOR'S SIGNATURE <u>Norman W. Sanderlader</u>	ADDRESS <u>802 Union St</u>
--	--	---	-----------------------------

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

MAY 13 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph 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.