

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**FILED DEC 20 1956**

State File No. **43704**  
 Registrar's No. **10845**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>University City</b>	
c. LENGTH OF STAY (in this place) <b>5 wks.</b>		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1261 Hafner Pl.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Louis</b>	b. (Middle) <b>K.</b>	c. (Last) <b>Puellman, Sr.</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>11 25 56</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 11, 1897</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Mildred Puellman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>James L. M... M.D.</b>	
				ADDRESS <b>1261 Hafner</b>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6 MO ?</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>BRONCHOGENIC CARCINOMA</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <b>CONFIRMED ABOVE</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>162x</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 the deceased from **8-27-1956** to **11/25**, 1956, that I last saw the deceased alive on **11/23**, 1956, and that death occurred at **2:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>James L. M... M.D.</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>634 N. Grand Blvd. St. Louis</b>	23c. DATE SIGNED <b>11/26/56</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>11/28/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>

DATE REC'D BY LOCAL REG. <b>NOV 27 1956</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Drehmann-Harral</b>	ADDRESS <b>1905 Union</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10-48

Dr. Mudd  
St. Johns Hospital

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.....  
Signature of Student Embalmer

Signed *Warren A. Caw*.....

Licensed Embalmer No. *353*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.