

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034817

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8542

FILED SEP 21 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |   | c. CITY OR TOWN <b>St. Louis</b>  |   |
| Length of stay in 1b  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>   |   | d. STREET ADDRESS (If outside, give location)<br><b>3959 Cottage</b>  |   |
| Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>David</b> Middle <b>Senell</b> Last <b>Puckett</b>  |   |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>26</b> Year <b>61</b> |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-26-61</b>                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (last birthday)<br>Months <b>1</b> Days <b>41</b>        |
| 11. BIRTHPLACE (City and state or country)<br><b>Saint Louis, Missouri</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |   |
| 13a. FATHER'S NAME<br><b>David Puckett</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Barbara Jean Ryland</b>   |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier</b>   |   | Address   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Premature birth, Neonatal death</b><br>DUE TO (b)<br>DUE TO (c) <b>76 2-5</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Atelectasis</b><br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   | INTERVAL BETWEEN ONSET AND DEATH                                |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour <b>4:00</b> a.m. p.m.   |   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. I attended the deceased from <b>8-26-61</b> to <b>8-26-61</b> and last saw him <input checked="" type="checkbox"/> alive on <b>8-26-61</b><br>Death occurred at <b>4:00</b> <b>p.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |
| 22a. SIGNATURE <i>Paul J. White</i> (Degree or title) <b>, M. D.</b>  |   | 22b. ADDRESS <b>2601 N. Whittier</b>  |   |
| 22c. DATE SIGNED <b>9-6-61</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>SEP 30 1961</b>   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b>   |   |
| 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b>  |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Rowland Mortuary Svc</b> ADDRESS <b>4104-06 Manchester</b>   |   | 25. DATE RECD. BY LOCAL REG. <b>SEP 14 1961</b>   |   |
| 26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>  |   |   |   |

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.