

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6162

1. PLACE OF DEATH
 County GREENE Registration District No. 318
 Township 2001 Primary Registration District No. 2001
 City SPRINGFIELD No. 108 E GRAND AVE St. 2 Ward 2
 2. FULL NAME J. PHARRIS PENNEL
 (a) Residence. No. 108 E GRAND St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 165
 _____ St. _____ Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-5-1900

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
23 6 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work STUDENT
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER R O Pennel

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Esther Dutee

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
 (STATE OR COUNTRY)

14. INFORMANT Thos C E Johnson
 (Address) Seneca Mo

15. Filed 9/15/29 by V. Horst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-18-1929

17. I HEREBY CERTIFY, That I attended deceased from 2-17-, 1929, to 2-18-, 1929.
 that I last saw him alive on 2-18-, 1929, and that death occurred, on the date stated above, at 2 Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza & Pulmonary Oedema
IIA
IIIB (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED Mo

IF NOT AT PLACE OF DEATH, _____

Did an operation precede death? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) C. E. Zeller M. D.

2-20, 1929 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

ME HOPE - DOPHIN - 2/21 1929

20. UNDERTAKER

HERMAN LOHMEYER ADDRESS SPRINGFIELD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. MAR 22 1929

WRITE COMPLETELY WITH UNFADING INK—THIS IS A PERMANENT RECORD

