

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

Do not use this space.

19935

1. PLACE OF DEATH

County.....

Registration District No. *111*

Township.....

Primary Registration District No. *1003*

City *St. Louis Mo.* (No. *1003*)

Sanitarium

File No. *5560*

Registered No.

St. _____ Ward)

2. FULL NAME

Katherine B. Penlon

(a) Residence. No. *1740 Mississippi St.* *13* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *53* yrs. *10* mos. *2* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 17, 1875

7. AGE

YEARS

53

MONTHS

10

DAYS

1

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

Dishwasher

(b) General nature of industry, business, or establishment in which employed (or employer).....

Unknown

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ireland

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ireland

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

*Dr. Joseph A. Scopelito
St. Louis City Sanitarium*

15.

MAILED

MAY 20 1929

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 18* 19*29*

17.

I HEREBY CERTIFY, That I attended deceased from *May 18*, 19*29*, to *May 18*, 19*29*, that I last saw him alive on *May 18*, 19*29*, and that death occurred, on the date stated above, at *5:30 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

93C (duration) / yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

90B

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical

(Signed) *Joseph A. Scopelito* M. D.

May 18, 1929 (Address) *St. Louis City Sanitarium*

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

Mt Olive

5/21 1929

20. UNDERTAKER

ADDRESS

Southern U & L Co

*7315
S. Broadway*

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.

1513-1-244

