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

Do not use this space.

577

1. PLACE OF DEATH

28 County Crawford — Registration District No. 229 — File No.

Township Boone — Primary Registration District No. 5211 — Registered No.

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Unknowned

(a) Residence. No. ..... 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	White	infant.

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 16 hrs. or ..... min.
			1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work infant. 15 mo 16 d

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Finn Pennock.

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

12. MAIDEN NAME OF MOTHER Elsie Jane Jones.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Shelby Co
(STATE OR COUNTRY) Ill. 2

14. INFORMANT Father
(Address) Bourbon Mo

15. FILED 1-5, 1932 C W Adams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH 2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1932

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 Jan 3, 1932, to Jan 3, 1932 that I last saw him alive on Jan 3, 1932 and that death occurred, on the date stated above, at 11 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Abnormal Pulmonary Circulation (Blue Baby)

15 mo (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF (1)

0 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? physical Diag

(Signed) R P Royse, M.D

, 19 (Address) Sullivan.

*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
Rock Cemetery	Jan 5 1932
20. UNDERTAKER	ADDRESS
Family	

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.

JAN - 0 1932