

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.

REC'D DEC 14 1938

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

38052
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 1002

(b) Township Blue Primary Registration District No. _____ Registered No. 4286

(c) City Kansas City Mo. (d) Street No. Kansas I. B. Hospital St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ira Pennington

(a) Residence, No. 2813 Holmes St. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar-30-1893

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>45</u>	<u>6</u>	<u>1</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. Unknown

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Arkansas

FATHER

13. NAME Francis Pennington

14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Arkansas

MOTHER

15. MAIDEN NAME Sarah Bush

16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Texas

17. INFORMANT K. C. M. J. B. Hospital (ADDRESS) Leeds, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wood Hills DATE Nov 4 1938

19. FUNERAL DIRECTOR (NAME) Mrs C. L. Farris (ADDRESS) _____

20. FILED 11-2-38 M. M. Crowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 1, 1938

22. I HEREBY CERTIFY, That I attended deceased from Oct 13 1938 to Nov 1 1938

I last saw h. i. m. alive on Nov 1 1938 Death is said to have occurred on the date stated above, at 2:39 P. m.

The principal cause of death and related causes of importance were as follows:

Pulmonary tuberculosis

23

Other contributory causes of importance: Chronic asthma

Date of onset 1-1-35

Name of operation none Date of _____

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

M. M. Crowe M. D. (Address) Kansas City Mo

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

Registered Apprentice No....., working under my personal supervision.

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 this body is not embalmed, above space should be left blank.