

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2924

Registration District No. 485-

Primary Registration District No. 5-64

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Steffenville
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 30 years
years, months or days _____

3. (a) PRINT FULL NAME Jacob Calvin Pence

8. (b) If veteran, name war No. 8. (c) Social Security No. _____

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Amelia Pence 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 2 1875
(Month) (Day) (Year)

8. AGE: Years 64 Months 11 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace Plerna Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Solomon Pence

18. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Susan Hickman

15. Birthplace Plerna Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mollie M. Banard

(b) Address Shepherdville, Mo. R. 3

17. (a) Burial (b) Date thereof Jan 20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steffenville

18. (a) Signature of funeral director Thomas Ball

(b) Address Ewing Mo.

19. (a) Jan 20-40 (b) Alvin M. Deane
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis
(c) City or town Steffenville - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28 1940
year 1940 hour 6 minute 26 P. M.

21. I hereby certify that I attended the deceased from April 29 to Jan 28, 1940
that I last saw him alive on Jan 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Nephritis
Chronic Myocarditis 1934
Duration 2 years

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 121

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of injury) _____ (e) Means of injury 1

23. Signature Waldo B. Brown M. D. of State _____

Address Newark, Mo. Date signed 1/30/40

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.

RECEIVED

District Health Officer No. 10

District File Number 2-40-267

Date Filed FEB 10 1940

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 Thomas Ball

Licensed Embalmer No. 1744

P. O. Address Ewing Mo

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.