

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.

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

14950
Do not use this space.

MAY 13 1940

1. PLACE OF DEATH
 (a) County GREEN Registration District No. 317
 (b) Township POND CREEK Primary Registration District No. 5437
 (c) City or (d) Street No. 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 ELBERT S. DENNY
 (a) Residence, No. GREEN COUNTY MO St.
 (Usual place of abode, if no street address, write county or city) (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 <u>MARIE MCDANIEL</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 1st 1871</u>				
7. AGE	YEARS <u>69</u> ✓	MONTHS <u>4</u>	DAYS <u>27</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>FARMER</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>FARM</u>			
	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) <u>ARK.</u>				
FATHER	13. NAME <u>LEROY DENNY</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>TENN.</u>			
MOTHER	15. MAIDEN NAME <u>MARTHA HASH</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>ARK.</u>			
17. INFORMANT <u>SHERL DENNY</u> (ADDRESS) <u>REPUBLIC MO.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>WADES CHAPEL</u> DATE <u>APRIL 30 1940</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>R. E. THURMAN</u> <u>REPUBLIC MO.</u>				
20. FILED <u>Apr 30 1940</u> <u>Mrs Bertha Nancy</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<u> </u> , 19 <u> </u>
22. I HEREBY CERTIFY , That I attended deceased from <u>Oct 1 - 1939</u> , to <u>April 28</u> , 19 <u>40</u> . I last saw him alive on <u>April 27</u> , 19 <u>40</u> . Death is said to have occurred on the date stated above, at <u>11 a. m.</u> The principal cause of death and related causes of importance were as follows: <u>Chronic Myocarditis</u> <u>Arteriosclerosis</u> Other contributory causes of importance: <u> </u>	
Name of operation <u>None</u> Date of <u> </u>	
What test confirmed diagnosis? <u>Chinid</u> Was there an autopsy? <u>Yes</u>	
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? <u> </u> Date of injury <u> </u> , 19 <u> </u> Where did injury occur? <u> </u> (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.	
Manner of injury <u> </u> Nature of injury <u> </u>	
24. Was disease or injury in any way related to occupation of deceased? <u>Yes</u> If so, specify <u> </u> (Signed) <u>E. M. LeCombe</u> , M. D. <u>280</u> (Address) <u>Brantley Lane NW</u>	

RECEIVED

Greene County Health Office,

County File Number 40-5-18

Date Filed 5-6-40

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.....

R E Thurman & Son

....., Registered Apprentice No.....

working under my personal supervision.

Signed *R E Thurman*

Licensed Embalmer No. 500

P. O. Address Republic, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14950

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 217

Primary Registration District No. 3437

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Greene
(b) City or town: Ponderosa T. P.
(If outside city or town limits, write "RURAL" and name of township)
(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: years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: (b) County:
(c) City or town: (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

3. (a) PRINT FULL NAME

Albert S. Penney

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: m

5. Color or race: w

6. (a) Single, widowed, married, divorced: m

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased: Dec-1-1891
(Month) (Day) (Year)

8. AGE:

Years: 68, Months: 4, Days: 27

If less than one day hr. min.

9. Birthplace:

(City, town, or county)

(State or foreign country)

10. Usual occupation:

11. Industry or business:

12. Name:

13. Birthplace:

(City, town, or county)

(State or foreign country)

14. Maiden name:

15. Birthplace:

(City, town, or county)

(State or foreign country)

16. (a) Informant:

(b) Address:

17. (a):

(b) Date thereof:

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation:

18. (a) Signature of funeral director:

(b) Address:

19. (a):

(Date received local registrar)

(b):

Mrs Beetha Nancy

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Apr. 28, day: 28, year: 1940, hour: 11 A.M., minute: M.

21. I hereby certify that I attended the deceased from Oct 1 1939 to Apr 28 1940
that I last saw h. alive on and that death occurred on the date and hour stated above.
Immediate cause of death:

Duration

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

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 place)

(e) Means of injury:

23. Signature:

E. M. LeCompt (M. D. or other)

Address:

Genevieve Station Date: Apr 28

SUPPLEMENTAL COPY

S-14950