

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

State File No. 36497  
 Registrar's No. 158

Registration District No. 796 Primary Registration District No. 6039

1. PLACE OF DEATH:  
 (a) County Saline Mo  
 (b) City or town Marshall Rural  
 (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 2  
 In this community 68 yrs  
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Gould Pannell  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 11 1872  
 (Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Clark Pannell  
 13. Birthplace \_\_\_\_\_  
 14. Maiden name Martha Jane Goring  
 15. Birthplace \_\_\_\_\_

16. (a) Informant Mrs. Eddie E. Hammer  
 (b) Address Marshall Mo

17. (a) Burial (b) Date thereof Oct. 14, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Ridge Park Cem.

18. (a) Signature of funeral director Campbell-Cover  
 (b) Address Marshall Mo

19. (a) 10-14-40 (b) Mary Kent  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Saline  
 (c) City or town Rural  
 (d) Street No. One mile south of Marshall  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct. day 12<sup>th</sup>  
 year 1940 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from Aug 8  
 1930 to Dec 12 1940  
 that I last saw him alive on Oct 10 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis  
 Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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?  
Yes (Specify type of place) \_\_\_\_\_  
 While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address [Address] Date signed 10/14/40

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

RECEIVED  
District Health Officer No. 8  
District File Number 11-13-40  
Date Filed

**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

*B. W. Campbell*

Licensed Embalmer No. 3469

P. O. Address Marshall N.C.

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.