

S. No. 2  
1-14-41  
5-17-5  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17991

State File No.

Registrar's No.

Registration District No. 387

Primary Registration District No. 5540 ✓

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town Rural  
(c) Name of hospital or institution: 1  
(d) Length of stay: In hospital or institution Thirty Six years  
In this community Thirty Six years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell  
(c) City or town Rural  
(d) Street No. 0  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Thomas Pendergast

3. (b) If veteran, name war: No. 3. (c) Social Security No. No.

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Josephine Pendergast 6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased December 1, 1874

8. AGE: Years 66 Months 5 Days 26 If less than one day hr. min.

9. Birthplace Kilkee (county Claire) Ireland

10. Usual occupation Bar tender

11. Industry or business

MOTHER FATHER { 12. Name James Pendergast  
13. Birthplace Ireland  
14. Maiden name Honora O'Connell  
15. Birthplace Ireland

16. (a) Informant Josephine Pendergast  
(b) Address Rt. 1, Panama, Mo.

17. (a) Burial (b) Date thereof May 29, 1941

(c) Place: burial or cremation White Church Cemetary

18. (a) Signature of funeral director J. Burns  
(b) Address Willow Springs, Missouri.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1941 hour 3 minute 50 A.M.

21. I hereby certify that I attended the deceased from May 23 1941 to May 23 1941  
that I last saw h. alive on May 23 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Asthma Duration 2 weeks

Due to 95C

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?

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

23. Signature P. H. Gussy (M. D. or other) OM.D  
Address West Plains, Mo Date signed 5/28/41

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

RECEIVED

District Health Officer No. 5,

District File Number 6411709

Date Filed 6/6/41

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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.....

Thomas R. Burns, Jr...... Registered Apprentice No. 251  
working under my personal supervision.

Signed J. C. Burns  
Licensed Embalmer No. 3379

P. O. Address Willow Springs, Missou

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 387

Primary Registration District No. 2540

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Dry creek 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 years, months or days)

3. (a) PRINT FULL NAME Thomas Pendergast

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 w

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 66 Months 5 Days 26 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8-12 (b) Dora Page  
(Data received local registrar) (Registrar's signature)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month May day 27  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature P. D. Gunn (M. D. or other) \_\_\_\_\_  
Address West Plains \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-17991