

13925

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 21 1942

Registration District No. _____

Primary Registration District No. 51794070

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Jackson Town
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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 23 yrs

8. (a) PRINT
FULL NAMEGeorge Washington Penny

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Male5. Color or
race W6. (a) Single, widowed, married,
divorced Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased August
(Month)24 1861
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

8085

hr. _____ min.

9. Birthplace

Cair Ridge

(City, town, or county)

Missouri

(State or foreign country)

10. Usual occupation

Retired Farmer

11. Industry or business

12. Name George Cabben Penny18. Birthplace Daisy

(City, town, or county)

OMO

(State or foreign country)

14. Maiden name Emily Drum15. Birthplace Daisy

(City, town, or county)

OMO

(State or foreign country)

16. (a) Informant's own signature Vane Snider(b) Address Jackson MO17. (a) Burial
(Burial, cremation, or removal)(b) Date thereof May 1 1942
(Month) (Day) (Year)(c) Place: burial or cremation New Salem18. (a) Signature of funeral director Wilson Stubb Seabaugh(b) Address Jackson MO19. (a) 1/30 1942
(Date received local registrar)(b) J. H. Keubert
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
 (c) City or town Jackson MO
 (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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 29th
 year 1942 hour 8 minute 20 AM

21. I hereby certify that I attended the deceased from Dec
20th 1941 to Apr 29 1942
 that I last saw him alive on Apr 29 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia / 14 hrs Duration

Due to Paralysis / 2 moDue to Cerebral hemorrhage / 2 mo

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 sta-
tistically.

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 T E Ruff (M. D. or other) MD
 Address Jackson MO Date signed Apr 29

1116

(Licensed Embalmer's Statement on Reverse Side)

REV. 5-17-39
I X19511

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

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 im-

RECEIVED
District Health Officer No. 4
District File Number 542-656
Date Filed 5-18-41

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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. 13923-

Registration District No. _____

Primary Registration District No. 4070

Registrar's No. _____

1. PLACE OF DEATH: Cape Girardeau

(a) County _____

(b) City or town _____
(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 Mo (b) County Cape Girardeau

(c) City or town Jackson
(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 _____

3. (a) PRINT FULL NAME George W. Penny

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 _____ years

7. Birth date of deceased: Aug. 24 - 1864
(Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 29 Year 1942 Hour 8 Minute 30 a. M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____; _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: lobar pneumonia
Paralysis (cerebral)
cerebral hemorrhage

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

Duration 2 1/2 hrs

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

