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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED DEC 4 1944**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38967

State File No. ....

Registration District No. 321

Primary Registration District No. 4494

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County SCOTT

(b) City or town COMMERCE  
(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) 1

(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether years, months or days) \_\_\_\_\_ (Specify whether)

In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME ARTHUR PENN

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife FRANCIS PENN

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased FEB. 3 1865  
(Month) (Day) (Year)

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

79 5 20 hr. min.

9. Birthplace CAPE Co. MO  
(City, town, or county) (State or foreign country)

10. Usual occupation RAILROAD

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

MOTHER FATHER { 12. Name JOSEPH PENN

13. Birthplace TENNESSEE  
(City, town, or county) (State or foreign country)

14. Maiden name MARALA KIRK

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

16. (a) Informant FRANCIS PENN

(b) Address COMMERCE MO.

17. (a) BURIAL (b) Date thereof 7-25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director BISPLINGHOFF-HUBBARD

(b) Address 122 MO MO.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County SCOTT

(c) City or town COMMERCE  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23<sup>rd</sup>  
year 1944 hour 2 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from June 10<sup>th</sup>, 1944, to July 23<sup>rd</sup>, 1944;  
that I last saw him alive on July 21<sup>st</sup>, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Glomerular Nephritis

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

Hypertension

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

131

Duration \_\_\_\_\_

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. P. Brogan (M. D. or other) D.O.

Address Deaton, Missouri Date signed 7-24-44

103K

(Licensed Embalmer's Statement on Reverse Side)

**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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 44844484Registration District No. 327Primary Registration District No. 4484

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

## 1. PLACE OF DEATH:

- (a) County Scott  
 (b) City or town Commerce  
 (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 days3. (a) PRINT  
FULL NAME Arthur Penn

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 \_\_\_\_\_ years

7. Birth date of deceased
- Feb. 3
- 
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- 
- 79
- 5
- MO
- 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 \_\_\_\_\_
- 
- (City, town, or county) (State or foreign country)

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)
- July 26, 44
- ; (b)
- Jos. L. Hawkins
- 
- (Date 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- July
- day
- 3
- 
- year
- 1944
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;
- 
- that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

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 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

38967