

FILED AUG 7 1947

Registration District No. **189**

Primary Registration District No. **1002**

Registrar's No. **3145**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 days**
In this community **33 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2425 College**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Joseph Blocker PENROD**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Clemma L. Penrod** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 29 1865**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 11 25 hr. min.

9. Birthplace **Wooster, Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Contractor**

11. Industry or business **Self**

12. Name **Jacob Penrod**

13. Birthplace **Summerset Co., Pa.**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Fouché**

15. Birthplace **Summerset Co., Pa.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm. A. Penrod**

(b) Address **2500 Indep. Ave., K.C., Mo.**

17. (a) **Burial** (b) Date thereof **7-26-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Melody-McGilley-Eylar**

(b) Address **Kansas City, Missouri**

19. (a) **7-26-47** (b) **Heraldine Holme**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**
year **1947** hour **6** minute **15** A.M.

21. I hereby certify that I attended the deceased from **July 11 1947** to **July 24 1947**;
that I last saw him alive on **July 24 1947**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral vascular accident**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy **None**

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? _____

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

23. Signature **Wm. A. Penrod** (M. D. or other) **MD**
Address **Med. Dir. Gen'l Hosp.** Date signed **7-24-47**

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

MOTHER FATHER

Dr. L. J. ...

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..... *Glen E. Heck*

Licensed Embalmer No. *4063*

P. O. Address..... *K. C. 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.