

FILED DEC 31 1947

Registration District No. **152**

Primary Registration District No. **5-5-72**

Registrar's No. **213**

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Jackson Co. Home for aged
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14.5 mth - 9 d
(Specify whether years, months or days)

In this community Unknown

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. Unknown
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME FRANK HENNINGER

3. (b) If veteran, name war -P-

3. (c) Social Security No. -?-

4. Sex M **5. Color or race** W

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: _____
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>			hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____ 9

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

14. Maiden name _____ 9

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

16. (a) Informant: Jackson Co. Home Records

(b) Address: P.R. #4, duplex mo

17. (a) (Anatomical, (b) Date thereof: 12-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: K.C. Col. Post + Surgery

18. (a) Signature of funeral director: N. B. ...

(b) Address: Lee's Summit Mo

19. (a) (Date received local registrar): 12-12-47 **(b) (Registrar's signature):** Donald C. Barnhart

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1947 hour 5 minute A.M.

21. I hereby certify that I attended the deceased from Sept 1, 1947 to Dec 3, 1947
that I last saw him alive on Dec 2, 1947
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? _____

While at work? _____ **(Specify type of place)** _____ **(c) Means of injury:** _____

23. Signature: J.P. Greene **(M. D. or other):** _____

Address: Independence Mo **Date signed:** 12/3/47

MOTHER FATHER

Duration

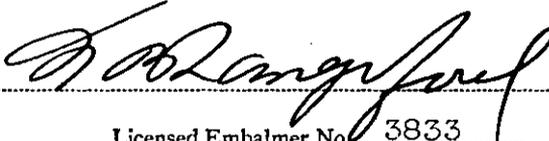
PHYSICIAN

Underline the cause to which death should be charged statistically.

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 

Licensed Embalmer No. 3833

P. O. Address Lee's Summit Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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 DEATH

State File No. Jan 213
Registrar's No. 213

Registration District No. 12-0

Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural
(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)

3. (a) PRINT FULL NAME Frank Penninger

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, unknown

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 67 Months Days If less than one day hr. min.

9. Birthplace unk
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Data received local registrar) (b) (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 Jan Day 19 Year 1941 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from 1941 to 1941; that I last saw him alive on 1941 and that death occurred on the date and hour stated above. Immediate cause of death unknown

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 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

SUPPLEMENTARY

MOTHER FATHER

42036