No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED FEB 24 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7425

Registration District No. 37 Primary Registration District No. 6076 Registrar's No. 429

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town rural Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 409 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1628 Park?
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ROLLA LUCILLE PENBERTHY
3. (b) If veteran, name war
3. (c) Social Security No. 490-22-1587

4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Virgil Penberthy
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased Feb (Month) 24 (Day) 1893 (Year)

8. AGE: Years 54 Months 11 Days 20 If less than one day hr. min.

9. Birthplace Caledonia, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation factory
11. Industry or business

MOTHER FATHER
12. Name Sherman Akers
13. Birthplace Caledonia, Mo. (City, town, or county) (State or foreign country)
14. Maiden name Ida Queen
15. Birthplace Caledonia, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Robert Koch Hospital records
(b) Address Koch, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/48 (Month) (Day) (Year)
(c) Place: burial or cremation Flat River, Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 2-14-48 (Date received local registrar) (b) Paul [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13 year 1948 hour 11 minute 25 a.m.

21. I hereby certify that I attended the deceased from 12-31-46, 19, to 2-13-48, 19; that I last saw h. alive on 2-13-48, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	2 years
Due to: 13 b	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Bernard Friedman (M. D. or other) MD
Address Robert Koch Hospital Date signed 2-13-48

Jefferson City Printing Co.
(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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address St. Louis

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.