

FILED JUN 1 1949

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 16847

BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>3054</u>		Registrar's No. <u>43</u>	
1. PLACE OF DEATH a. COUNTY <u>PIKE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LOUISIANA U</u>		c. LENGTH OF STAY (In this place) <u>6 DAYS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BOWLING GREEN, MO.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>PIKE COUNTY HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>1206 W MAIN ST</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROBERT</u> b. (Middle) <u>WILLIAM</u> c. (Last) <u>DRENNEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 20 1949</u>				
5. SEX <u>MU</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED 1</u>	8. DATE OF BIRTH <u>MAY 10 1884</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u>	IF UNDER 12 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MECHANICS</u>		11. BIRTHPLACE (State or foreign country) <u>FAIRO, NEB.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>MATHEW DRENNEN</u>			13b. MOTHER'S MAIDEN NAME <u>EVA OWEN</u>		14. NAME OF HUSBAND OR WIFE <u>IDA DRENNEN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>270-05-5008</u>		17. INFORMANT'S SIGNATURE OR NAME <u>IDA DRENNEN</u> ADDRESS <u>BOWLING GREEN MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Unemia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Hypertensive Cardiac</u> <u>Arterial Renal Disease</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 days</u> <u>?</u> <u>442X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>5-15, 1949</u> , to <u>5-20, 1949</u> , that I last saw the deceased alive on <u>5-20, 1949</u> and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Christ Hanelle M.D. U</u>				23b. ADDRESS <u>Louisiana, Mo.</u>		23c. DATE SIGNED <u>5-21-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>MAY 23-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MOUNT VERNON</u>		24d. LOCATION (City, town, or county) (State) <u>WASH BURN ILL</u>	
DATE REC'D BY LOCAL REG. <u>May 21, 1949</u>		REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. G. Mudd Funeral Home Bowling Green, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 1

District File Number 5-4992

Date Filed MAY 31 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed James O. Mudd

Licensed Embalmer No. 4152

P. O. Address Bowling Green Wyo.

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.