

FILED JUN 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 20039

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 162 PRIMARY REG. DIST. NO. 5595 Registrar's No. 39

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Jefferson County                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE Mo b. COUNTY Jefferson |  |
| b. CITY (If outside corporate limits, write RURAL and give township) Arnold Rock |  | c. CITY (If outside corporate limits, write RURAL and give township) Arnold - Mo.  |  |
| c. LENGTH OF STAY (In this place)  |  | d. STREET ADDRESS (If rural, give location) Arnold - 0   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Arnold                                   |  |  |  |

|   |                    |  |  |                                    |                                   |
|---|--------------------|--|--|------------------------------------|-----------------------------------|
| 3. NAME OF DECEASED<br>(Type or Print) (First) (Middle) (Last)<br>Pammy (Steward) Jevengood           |                    |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>June 5 49 |                                    |                                   |
| 5. SEX F  | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct 12, 1972                      | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Days 26           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) House wife |                    | 10b. KIND OF BUSINESS OR INDUSTRY At Home                      | 11. BIRTHPLACE (State or foreign country) Mo       |                                    | 12. CITIZEN OF WHAT COUNTRY? U.S. |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 13a. FATHER'S NAME James M. Davis  |  | 13b. MOTHER'S MAIDEN NAME Virginia Ellen Davis |  | 14. NAME OF HUSBAND OR WIFE Wm S Jevengood              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.                        |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Max Risch |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Per Myocarditis  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
|   |  | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis |  |  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.               |  |  |  |
| 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 June 4, 1949, to June 4, 1949, that I last saw the deceased alive on June 4, 1949, and that death occurred at 4:05 pm, from the causes and on the date stated above.

|  |  |                         |  |   |  |
|--|--|-------------------------|--|---|--|
| 23a. SIGNATURE (Degree or title) Thelma M.S.     |  | 23b. ADDRESS Remmick Mo |  | 23c. DATE SIGNED 6/6/49                               |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial |  | 24b. DATE June 6/49     |  | 24c. NAME OF CEMETERY OR CREMATORY Civa Mo            |  |
|  |  |                         |  | 24d. LOCATION (City, town, or county) (State) Civa Mo |  |

|                                    |  |                                   |  |   |  |
|------------------------------------|--|-----------------------------------|--|---|--|
| DATE REC'D BY LOCAL REG. June 6-49 |  | REGISTRAR'S SIGNATURE Phil J Kirk |  | FUNERAL DIRECTOR'S SIGNATURE ADDRESS 140 S Wendler Rd @ 7420 M. Chicago |  |
|------------------------------------|--|-----------------------------------|--|---|--|

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

50 cc

RECEIVED  
District Health Officer No. 9,  
District File Number JUN 15 1949  
Date Filed

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 W. E. Mann

Licensed Embalmer No. 3360

P. O. Address.....

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.

W. E. Mann