

FILED OCT 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33883

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 200 Registrar's No. 448

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin 0495	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 717 St. Louis Ave.		d. STREET ADDRESS (If rural, give location) 315 Virginia Ave.	

3. NAME OF DECEASED (Type or Print) Otto L Pence			4. DATE OF DEATH Oct. 6 1950		
5. SEX 0 Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	
8. DATE OF BIRTH June 30, 1879		9. AGE (In years last birthday) 71 yrs 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.		10b. KIND OF BUSINESS OR INDUSTRY Cafe	

13a. FATHER'S NAME Frank Pence		13b. MOTHER'S MAIDEN NAME Mary McClachex		14. NAME OF HUSBAND OR WIFE Hazel E. Pence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 509-16-4945		17. INFORMANT'S SIGNATURE OR NAME Jerry Pence ADDRESS 717 St. Louis Ave.	

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 3 Days 331X	
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)		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 Jan 15, 1949, to Oct 6, 1950, that I last saw the deceased alive on 10-6, 1950, and that death occurred at 1:50 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)		23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial (1)		24b. DATE Oct. 7, 1950		24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
				24d. LOCATION (City, town, or county) (State) Joplin Missouri	

DATE REC'D BY LOCAL REG. 10-11-50		REGISTRAR'S SIGNATURE Ed S. [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thornhill-Dillon Joplin, Missouri	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 10-18-50
Jasper County Health Office
County File Number 50-10-746
Date Filed 10-18-50

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 Charles E. Frey

Licensed Embalmer No. 4768V

P. O. Address Joplin, 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.