

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHDr. Penninger  
State File No. 26805  
Registrar's No. 815-C

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>815-C</u>					
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u>				b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SPRINGFIELD</u>			c. LENGTH OF STAY (In this place) <u>6 WKS</u>	c. CITY OR TOWN <u>MT. VIEW</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BURGER-CONNELLY REST HOME</u>				e. STREET ADDRESS (If rural, give location) <u>0460</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ISSAC</u>			b. (Middle) <u>W.</u>		c. (Last) <u>CHOWNING</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 27, 1954</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 18, 1874</u>		9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>HOWELL COUNTY, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>JASPER CHOWNING</u>			13b. MOTHER'S MAIDEN NAME <u>MARY JANE WELLER</u>			14. NAME OF HUSBAND OR WIFE <u>PRUDIE CHOWNING</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknowns) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS OLA FENDER</u>					ADDRESS <u>1522 E. CENTRAL</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH			
		ANTECEDENT CAUSES DUE TO (b) <u>Circulatory failure</u>									
		DUE TO (c) <u>Arteriosclerotic Cardio-vascular Disease</u>									
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Rheumatoid Arthritis</u>									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4221</u>						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 <u>July 9, 1954</u> , to <u>Aug 27, 1954</u> , that I last saw the deceased alive on <u>August 27, 1954</u> , and that death occurred at <u>4:45 p.m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <u>Dr. H. Penninger</u>				(Degree or title) <u>M.D. Medical Director</u>		23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>Aug 28, 1954</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>8/27/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>NEAR MT VIEW, MO.</u>		24d. LOCATION (City, town, or county) (State) <u>MT. VIEW, MO.</u>					
DATE REC'D BY LOCAL REG. <u>9-30-54</u>		REGISTRAR'S SIGNATURE. <u>Edith Kellerman</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>HERMAN H. LOHMEYER</u>					ADDRESS <u>SPRINGFIELD</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 7 1956

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.....  
Signature of Student Embalmer

Signed..... *Gene C. Hunter*

Licensed Embalmer No. *473*

P. O. Address *Springfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.