

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29917

State File No. ....

1030

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. ....

2

1. PLACE OF DEATH a. COUNTY <u>Buchanan.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Joseph.</u> )	c. LENGTH OF STAY (in this place) <u>31 days 11 M 26 days</u>	c. CITY OR TOWN <u>Kansas City</u>	Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2</u>		e. STREET ADDRESS (If rural, give location) <u>24th &amp; Cherry.</u> <span style="float: right;">3568</span>	
3. NAME OF DECEASED a. (First) <u>CARL</u> b. (Middle) <u>-</u> c. (Last) <u>PENNINGTON.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-19-1956.</u>	
5. SEX <u>Male.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>9-24-1905.</u>
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>George Pennington.</u>	
13b. MOTHER'S MAIDEN NAME <u>Anna Kinnard.</u>		14. NAME OF HUSBAND OR WIFE <u></u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None.</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>G. W. Johnson, 1718 Jefferson, Kansas City Mo.</u>		ADDRESS <u></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, atheria, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 mos +</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Degeneration of myocardium</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>mental deficiency</u> <u>Since birth</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4222</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u></u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u></u>		22. I hereby certify that I attended the deceased from <u>1-7-</u> , 1956, to <u>9-19-</u> , 1956, that I last saw the deceased alive on <u>9-19-</u> , 1956, and that death occurred at <u>4:00 p. m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>J. H. Marroway</u>		23b. ADDRESS (Degree or title) <u>M.D., State Hospital No. 2, St. Joseph, Mo.</u>	
23c. DATE SIGNED <u>9-19-1956.</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>Sept 23rd</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Freemont Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Freemont Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter M. Allison Wilks</u>	
25. ADDRESS <u>Home KC MO</u>		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Sept 24, 1956</u>	

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

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**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... *Chas E. Wilks* .....

Licensed Embalmer No. *2641* .....

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