

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **4360**

FILED FEB 18 1957

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>144</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>Wright</u>							
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>11/40</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mountain Grove</u>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>321 W. North St.</u>							
3. NAME OF DECEASED (Type or Print) <u>IDA</u>			a. (First) <u>PENN</u>		b. (Middle)		c. (Last)				
4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 8 1957</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed 2</u>		8. DATE OF BIRTH <u>April 9, 1878</u>			
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>9</u>		IF UNDER 1 YEAR Days <u>29</u>		IF UNDER 12 HRS. Hours <u>29</u>		IF UNDER 12 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Seymour, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Foster Davis</u>			13b. MOTHER'S MAIDEN NAME <u>Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>Cyrus Penn</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>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Harry Brixey</u>				ADDRESS <u>Mountain Grove, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>Hypertension and Arteriosclerotic H. obs.</u>				DUE TO (c)				3 years			
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  <u>4200</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) <u>Springfield Mo.</u>							
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>Feb 7, 1957</u> to <u>Feb 8, 1957</u> , that I last saw the deceased alive on <u>Feb 8, 1957</u> and that death occurred at <u>9:40 A. M.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <u>E. S. Miller M.D.</u>				23b. ADDRESS <u>Professional Bldg. Springfield Mo.</u>		23c. DATE SIGNED <u>2/11/57</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-10-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Brixey</u>		24d. LOCATION (City, town, or county) (State) <u>Seymour, Missouri</u>					
DATE REC'D BY LOCAL REG. <u>2-12-57</u>		REGISTRAR'S SIGNATURE <u>Earl Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leable-Windle Suth Sr. Mo.</u>							

(Licensed Embalmer's Statement on Reverse Side)

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

**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

*Frank Stable*

Licensed Embalmer No. *4160*

P. O. Address *State House, Me*

**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.