

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16389

STATE FILE NUMBER

FILED MAY 22 1957

Registration District No. 389 Primary Registration District No. 5163 Registrar's No. 11

Health,
& Welfare
Public
Service

S. 300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cote San Messer in Top</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Tebbetts</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 1/2 N. Tebbetts</u> Length of stay in lb <u>WIFE</u>		d. STREET ADDRESS (If outside, give location) <u>WIFE</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>Pannell</u> Last <u>Pannell</u>			4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>57</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12-1971</u>
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Month <u>5</u> Day <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Callaway County Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</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 Address <u>James Pannell Tebbetts Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CONGESTIVE HEART DISEASE</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u> <u>2 YRS.</u> <u>15 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>11</u> a. m. <u>45</u> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>MAY 8, 1957</u> to <u>MAY 14, 1957</u> and last saw her alive on <u>MAY 14, 1957</u> Death occurred at <u>11-45</u> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William A. Law D.O.</u>		22b. ADDRESS <u>500 Lafayette St. City Mo</u>	
22c. DATE SIGNED <u>5/15/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>May 18-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakley Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Tebbetts</u>		23e. STATE <u>MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Holt Claypool New Bloomfield Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May-15-57</u>	
26. REGISTRAR'S SIGNATURE <u>LeRoy Claypool</u>			

(Licensed Embalmer's Statement on Reverse Side)

395

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..... *Le Roy Clempool*
Licensed Embalmer No. 441

P. O. Address... *New Orleans*

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.