

Health,
Public
Service

FILED SEP 9 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 853

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hosp.		d. STREET ADDRESS (If outside, give location) RFD#10	
3. NAME OF DECEASED (Type or print) First OPAL Middle LUCILLE DRENNAN Last PEACOCK		4. DATE OF DEATH Month Aug. Day 30 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 May 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME John Drennan		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Tobey Peacock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Address Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma Teris of Abdomen Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Bilateral Ovarian Carcinoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 175X			INTERVAL BETWEEN ONSET AND DEATH 15 mos & longer ?
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 _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 May 1956 to 8/30/57 and last saw her alive on 8/29/57 Death occurred at 6:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. Roland Kingner, M.D. (Degree, or title)		22b. ADDRESS 609 Cherry Springfield, Missouri	
22c. DATE SIGNED 8/3/57		22d. DATE OF DEATH 8/30/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-1-57	23c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery	23d. LOCATION (City, town, or county) (State) Greene County, Mo.
24. FUNERAL DIRECTOR J.W. Kingner & Co. ADDRESS Spgrfd. Mo.		25. DATE RECD. BY LOCAL REG. 9-5-57	26. REGISTRAR'S SIGNATURE Edith Williamson

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

VS DEC 19 1961

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 Catherine Fleming

Licensed Embalmer No. 3719 P. O. Address

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.