pt. Health,
., & Welfare
S. Public
lth Service

S. 300
v. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-032204
STATE FILE NUMBER

FILED SEP 30 1958

Registration District No. 98 Primary Registration District No. 4160 Registrar's No. 81

1. PLACE OF DEATH
a. COUNTY DAVIESS
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) WINSTON — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY DAVIESS
c. CITY OR TOWN WINSTON 0310 0 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First CELESTA Middle JANE Last PENNINGTON

4. DATE OF DEATH Month Day Year SEPT-14-1958

5. SEX F 1
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH APRIL-12-1862
9. AGE (In years last birthday) 96 — IF UNDER 1 YEAR Months 5 Days 2 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) OHIO 1
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME EPHRAIM KUHNS
13b. MOTHER'S MAIDEN NAME MAGDALINA SHUTT
14. NAME OF ~~HUSBAND~~ OR WIFE LAWSON PENNINGTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. X
17. INFORMANT Flandie Smith Address Winston, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Senile Arterial Degeneration — INTERVAL BETWEEN ONSET AND DEATH 10 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 4500
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 ☐ NO ☐ 0

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 9-14-58 to 9-14-58 and last saw her/him alive on 9-14-58
Death occurred at 8:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Floyd E. Nelson M.D.
22b. ADDRESS Gallatin, Mo.
22c. DATE SIGNED 9-16-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 9-16-58
23c. NAME OF CEMETERY OR CREMATORY Winston
23d. LOCATION (City, town, or county) Winston (State) MO

24. FUNERAL DIRECTOR Virgil V. Strong ADDRESS Winston, Mo.
25. DATE RECD. BY LOCAL REG. 9-20-58
26. REGISTRAR'S SIGNATURE Virgil M Engelhart

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 L. O. Richardson

Licensed Embalmer No. 3302

P. O. Address Gadsden

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.