

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045246

STATE FILE NUMBER

FILED DEC 24 1958

Registration District No. 297 Primary Registration District No. 602 Registrar's No. 138

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>RAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>RAY</b>	
b. CITY OR TOWN <b>GRAPE GROVE</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>HARDIN</b> 0890 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b> Length of stay in lb <b>60 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>R.F.D. 1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>E LERNORA TEMPLE PENNY</b>			4. DATE OF DEATH Month Day Year <b>DEC. 18, 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 6, 1881</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (In years last birthday) <b>77</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>RAY COUNTY Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>ELI SPITZER</b>	
13b. MOTHER'S MAIDEN NAME <b>HARRIET RADER</b>		14. NAME OF HUSBAND OR WIFE <b>WILLIAM PENNY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT Address <b>FLOYD PENNY - HARDIN, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Accident</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>			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 Month, Day, Year a.m. p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" 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 <b>12-1-58</b> to <b>12-18-58</b> and last saw her alive on <b>12-18-58</b> Death occurred at <b>330 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>E E Gay M.D.</b> (Degree or title)		22b. ADDRESS <b>Chilhowe Mo.</b>	
22c. DATE SIGNED <b>12-19-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-19-58</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NEW HOPE CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>RAY COUNTY, Mo.</b>	
24. FUNERAL DIRECTOR <b>KNIPSCHILD &amp; BORCHARDING-HARDIN, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-20-1958</b>	
ADDRESS _____		26. REGISTRAR'S SIGNATURE <b>Malcolm Jackson</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed.

**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 *August Rockwell* .....

Licensed Embalmer No. *4628* .....

P. O. Address *Hardin, 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.