

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046150

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11648

S. 300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI			c. CITY OR TOWN Montgomery City		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			d. STREET ADDRESS (If outside, give location) 3/		
3. NAME OF DECEASED (Type or print) First Middle Last EMMA LEE PENNICK			4. DATE OF DEATH Month Day Year DECEMBER 2, 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1873		9. AGE (In years (by birthday)) 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) New Florence, Mo.	
13a. FATHER'S NAME Ezekiel McCarthy		13b. MOTHER'S MAIDEN NAME Carrie Johnson		14. NAME OF HUSBAND OR WIFE John	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rev. William Foster, Bonne Terre, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBO-EMBOLISM TO SUPERIOR MESENTERIC ARTERY					INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
DUE TO (b) MYOCARDIAL INFARCTION					48 HOURS
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE 4200F					YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) TRANSCERVICAL FRACTURE, RIGHT FEMORAL NECK					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) FELL ON RIGHT HIP WHILE WALKING ACROSS FLOOR			
20c. TIME OF INJURY Hour Month, Day, Year 11/28/58					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 19 Nursing Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE 4512 West Pine St. Louis, Missouri	
21. I attended the deceased from NOV. 28, 1958 to DEC. 2, 1958 and last saw her/him alive on DEC. 2, 1958 Death occurred at 1:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>W. M. D.</i>				22b. ADDRESS BARNES HOSPITAL	
				22c. DATE SIGNED 12/3/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-2-58		23c. NAME OF CEMETERY OR CREMATORY Local	
				23d. LOCATION (City, town, or county) (State) New Florence, Mo.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. DEC 3 '58		26. REGISTRAR'S SIGNATURE <i>Carl Smith, Mo</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON. WRITE IF POSSIBLE.

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12/3/58*

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 *Laurie O. Seeling*

Licensed Embalmer No. *4979*

P. O. Address *St. Louis*

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.