

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005797

STATE FILE NUMBER

707

FILED FEB 19 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300

1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Oak Grove 7000		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp		Length of stay in 15 56 yrs	d. STREET ADDRESS (If outside, give location) R.F.D. #2		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EVA Middle M. Last PENNINGTON			4. DATE OF DEATH Month 2 Day 5 Year 59		
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1890	9. AGE (In years at birthday) 60	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Ft. Scott, Kansas		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Wm. T. Wright		13b. MOTHER'S MAIDEN NAME Anna E. Nanson		14. NAME OF HUSBAND OR WIFE Wm. R. Pennington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (not unknown) (If yes, give number dates of service) XX		16. SOCIAL SECURITY NO. 487-16-3576	17. INFORMANT Address Mrs. Donald S. Carlson, 7021 Indiana		
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>Acute myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u> <u>4 years</u>
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 <input type="checkbox"/> WORK 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 <u>1-22-59</u> to <u>2-5-59</u> and last saw her alive on <u>2-4-59</u> Death occurred at <u>1:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Albert I. Decker M.D.</u> (Degree or title)			22b. ADDRESS <u>Kansas City, Mo.</u>		22c. DATE SIGNED <u>2-6-59</u>
23a. BURIAL, CREMATION, REPOSAL (Specify) <u>Burial</u>	23b. DATE <u>2-7-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>		23d. LOCATION (City, town, or country) (State) <u>Kansas City Mo</u>	
24. FUNERAL DIRECTOR <u>Wagner Funeral Home K C Mo</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-6-59</u>	26. REGISTRAR'S SIGNATURE <u>Arlo Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

Albert I. Decker USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

2120

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 *Thomas A. Kessler*

Licensed Embalmer No. *4995*

P. O. Address *H.C., 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.