

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008986

STATE FILE NUMBER

FILED APR 6 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 269A

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>West Plains</b> <sup>0460</sup>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>		Length of stay in 1b <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>West Plains, Missouri</b>
3. NAME OF DECEASED (Type or print) First <b>DANNY</b> Middle <b>JOE</b> Last <b>PENNELL</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>11</b> Year <b>1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 10, 1959</b>
9. AGE (In years last birthday) <b>0</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (City and state or country) <b>West Plains, Missouri</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Gale Pennell</b>		13b. MOTHER'S MAIDEN NAME <b>Belva Joyse Camden</b>	14. NAME OF HUSBAND OR WIFE
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>none</b>	17. INFORMANT Address <b>Mrs Gale Pennell, West Plains, 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>Vertex Meningeale + Spina Bifida</b> <b>Congenital Malformation</b> <b>Premature Birth.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>DUPLICATE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>UNATTENDED BY A PHYSICIAN</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Birth</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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Baby was sent in to Burge Premature Center and expired before being</b>	
20f. CITY, TOWN, OR LOCATION <b>Springfield, Missouri</b>		20g. COUNTY <b>Greene</b>	
20h. STATE <b>Missouri</b>		21. I attended the deceased from <b>seen by attending physician</b> and last saw <sup>her</sup> <sub>him</sub> alive on _____ Death occurred at <b>10 a.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>James R. Amos, M.D.</b> (Degree or title)		22b. ADDRESS <b>Springfield, Missouri</b>	
22c. DATE SIGNED <b>4-2-59</b>		22d. ADDRESS <b>Greene County Health Officer</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>Mar. 11, 1959</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>West Plains, Missouri</b>	
24. FUNERAL DIRECTOR <b>Beland Carter</b>		25. DATE RECD. BY LOCAL REG. <b>4-2-59</b>	
26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>		26. REGISTRAR'S SIGNATURE	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....  
Signature of Student Embalmer

Licensed Embalmer No. ....

P. O. Address .....

Note: The above ~~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.