

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021621

FILED JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2672

STATE FILE NUMBER

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 Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital, K.C. Mo.		Length of stay in institution 9 days	d. STREET ADDRESS (If outside, give location) 5628 Kenwood Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ROBERT Middle EAKEN Last PENFOLD			4. DATE OF DEATH Month 5th Day 29th Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/98	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ft. Wayne, Ind.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME James H. Penfold	13b. MOTHER'S MAIDEN NAME Laura M. Eaken EAKEN	14. NAME OF HUSBAND OR WIFE Mary Penfold
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) Yes WWII	16. SOCIAL SECURITY NO. 487-09-0295	17. INFORMANT Address VA HOSPITAL RECORDS, K. C. MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic pulmonary emphysema	5 years
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease		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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. **VA** attended the deceased from 5/21/59 to 5/29/59
Death occurred at 7:35 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Marvin L. Murphy</i>	22b. ADDRESS VA Hospital, K. C. Mo.	22c. DATE SIGNED 5/29/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 1, 1959	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURIA
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24. FUNERAL DIRECTOR Muehlebach	ADDRESS 6800 TROOST	25. DATE RECD. BY LOCAL REG. 5-30-59	26. REGISTRAR'S SIGNATURE <i>Marvin L. Murphy</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MARVIN L. MURPHY

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 *R. E. Nichols*

Licensed Embalmer No. *40997*

P. O. Address *K. 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.