

JRI DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

59-032038

Dr. Fitch filed VS OCT 5 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1024

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 84 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 701 W. SCOTT Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HENRY Middle J. Last PENLAND			4. DATE OF DEATH Month SEPT. Day 28 Year 1959		
--	--	--	---	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/21/75	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY GROCCER	11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	---

13a. FATHER'S NAME JAMES PENLAND	13b. MOTHER'S MAIDEN NAME ELIZABETH	14. NAME OF HUSBAND OR WIFE HELENA PENLAND (DEC.)
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 500-09-5210	17. INFORMANT Address MRS. HELEN BURNS SPRINGFIELD, 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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause first.	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) <u>Arterio Sclerosis</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 a.m. p.m. Month, Day, Year	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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--	--

21. I attended the deceased from <u>9-18-59</u> to <u>9-28-59</u> and last saw ^{her} him alive on <u>9-28-59</u> Death occurred at <u>11:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Theresa M. ...</i>	22b. ADDRESS <u>1712 Boonville Springfield Missouri</u>	22c. DATE SIGNED <u>9-29-59</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/30/59	23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD	23d. LOCATION (City, town, or county) SPRINGFIELD, MO.	23e. (State)
--	-----------------------------	--	--	--------------

24. FUNERAL DIRECTOR H.H. LOHMEYER SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 9-20-59	26. REGISTRAR'S SIGNATURE <i>Effie S. Meeton</i>
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS
OCT 19 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gene A. Bunker

Licensed Embalmer No. 1377

P. O. Address Edina

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.