

FILED MAR 7 - 1940

State File No. _____

Registration District No. 684

Primary Registration District No. 4408

Registrar's No. 13

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Bowling Green
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME Thomas Samuel Penn
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 13 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) S

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Penn

13. Birthplace Virginia (City, town, or county) (State or foreign country)

14. Maiden name Margaret Kraft

15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Huffer
(b) Address Bowling Green Mo

17. (a) Burial (b) Date thereof 2-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowling Green Mo

18. (a) Signature of funeral director Edward Bumpstead
(b) Address Bowling Green Mo
19. (a) _____ (b) W. B. Sumner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pike
(c) City or town Bowling Green
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 24
year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Jan 23
1940 to Feb 23 1940
that I last saw her alive on Feb 23 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis
Due to Chronic and Acute
Due to _____
Other conditions 781
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W. B. Sumner (M. D. or other) no
Address Bowling Green Mo Date signed 2/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM 5-17-39
REV. 5-17-39
U. S. GOVERNMENT PRINTING OFFICE: 1938

RECEIVED
District Health Officer No. 10
District File Number 3-40-487
Date Filed MAR 5 1940

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Guar Bankshead

Licensed Embalmer No. 2204

P. O. Address Bowling Green

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **7768**

Registration District No. **684**

Primary Registration District No. **4408**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Boonville**
 (b) City or town **Boonville**
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Thomas S. Penn**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **s**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **April 9th 1865**
 (Month) (Day) (Year)

8. AGE: Years **94** Months **10** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **Boonville, Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) **J. B. Summers**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **24**
 year **1950** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **J. H. Mathers** (M. D. or other) _____

Address **Boonville, Mo.** Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTAL

