

JAN 23 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42003

Registration District No. 1111

Primary Registration District No. 5160

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Walloway  
(b) City or town Cleveland, Tenn.  
(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) 3

3. (a) PRINT FULL NAME MARY ELLEN PENDLETON

3. (b) If veteran,  name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex f 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

(b) Name of husband or wife John C. Pendleton 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 18 1858  
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Gray Co Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation housekeeper

11. Industry or business \_\_\_\_\_

12. Name John C. Lawrie

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

14. Maiden name Maria Ann Stone

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

16. (a) Informant Mrs. Jack Wheeler

(b) Address Settler Mo.

17. (a) Medica Mo (b) Date thereof 12 29 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Medica Mo

18. (a) Signature of funeral director M. McDonald

(b) Address Cleveland Mo

19. (a) 1/2/1941 (b) B. H. Stephens  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 1 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26  
year 1940 hour 11 minute 55 AM

21. I hereby certify that I attended the deceased from Dec 24  
1940 to Dec 26 1940  
that I last saw her alive on Dec 26 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Pneumonia - Hypostatic  
Chronic myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None  
(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 Albert H. Stephens (M. D. or other) 1/2/40

Address Cleveland Mo Date signed 1/2/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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 *M. McQuinn*  
Licensed Embalmer No. *2589*  
P. O. Address *Centerville 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 this body is not embalmed, fact should be so stated above.**

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STANDARD CERTIFICATE OF DEATH

State File No. 42003

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 1111

Primary Registration District No. 5160

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Cleveland  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway  
(c) City or town Hutton (Rural)  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) Route 1  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary Ellen Pendleton  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Dec day 26  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

7. Birth date of deceased. (Month) (Day) (Year)  
8. AGE: Years 87 Months 4 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) Jan 2, 1941 (b) B. H. Stephens  
(Date received local registrar) (Registrar's signature)

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 T. M. Turner (M. D. or other)  
Address Centralia Mo Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940

S-42003