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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 1 1944

Registration District No. 14

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5 5 1 8

State File No. 14837

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C. Mo Ruth Buckner
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6400 James A. Reed Rd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution —
(Specify whether years, months or days)

In this community 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town K. C. Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 6400 James A Reed Rd.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME JAMES L. PENCE

3. (b) If veteran, name war no

3. (c) Social Security No. —

4. Sex M

5. Color or race wh

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife May

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov. 19 (Month) (Day) 1866 (Year)

8. AGE: Years 77 Months 3 Days 4 If less than one day ____ hr. ____ min.

9. Birthplace — (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation R. R.

11. Industry or business —

FATHER

12. Name Nelson Pence

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

MOTHER

14. Maiden name Margaret Elliott

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

16. (a) Informant Dr. H. A. Pence

(b) Address 2722 Prospect

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-28-44 (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo

18. (a) Signature of funeral director O. Mott Funeral Home

(b) Address 4346 Troost

19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24 year 1944 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from 12/2/43, 19__, to 2/24/44, 19__; that I last saw him alive on Feb. 4, 19 44 and that death occurred on the date and hour stated above.

Immediate cause of death acute cardic & respiratory failure. — Duration

Due to Myocarditis & senility

Due to

Other conditions (Includes pregnancy within 3 months of death) 93 yl

Major findings: Of operations

Of autopsy

PHYSICIAN — 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? (Specify type of place)

While at work? (Specify) (e) Means of injury

23. Signature E. D. Pontold (M. D. or coroner)

Address 4748 Prospect Date signed 2-25-44

(Licensed Embalmer's Statement on Reverse Side)

MAY 1

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 Howard G Roe

Licensed Embalmer No. 2748

P. O. Address K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 146 Primary Registration District No. 5068 Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Brooking Twp
(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 (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James L. Pence

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. 19 1866 (Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days 4 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3-29-44 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24 year 1944 hour minute M.

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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

14837