

FILED DEC 7 1944

Registration District No. 387

Primary Registration District No. 4588

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Wayne

(b) City or town Piedmont
(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 years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wayne!!!

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

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jennie Pennington

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17th year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept 25, 1944, to Oct 4, 1944, that I last saw her alive on Oct 4, 1944, and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife William R. Pennington 6. (c) Age of husband or wife if alive 4 years 1862

7. Birth date of deceased: Aug (Month) 4 (Day) 1862 (Year)

Immediate cause of death Cardio-vascular collapse

Due to decompensating heart & renal

Due to _____

8. AGE: Years 82 Months 2 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace St. Francis Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

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

Major findings: Of operations 950

Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Philip W. Shoner 4

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

14. Maiden name Ester Jane Jordan

15. Birthplace Rylands Co Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Miss M. Mabrey

(b) Address Piedmont Mo

17. (a) Burial (b) Date thereof Oct 8 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Masonic Cemetery, Piedmont

18. (a) Signature of funeral director William Boden

(b) Address Piedmont, Mo.

19. (a) Nov. 6, 1944 (Date received local health officer) (b) _____ (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 _____

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 W. H. Clum M.D. (M. D. or other)

Address Piedmont, Mo Date signed 10/6/44

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

1403

RECEIVED

Health Officer No. ⁴.....
File Number 12-44-4597
Date Filed 12-5-44

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.....

Coder Funeral Home Registered Apprentice No.....
working under my personal supervision.

Signed William Coder

Licensed Embalmer No. 3723

P. O. Address Piedmont, Va

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.

Registration District No. 369

Primary Registration District No. 4538

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Piedmont
(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. (a) PRINT FULL NAME

Jessie Pennington

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 4
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov 6, 1944 (b) Miss Lottie Mannes
(Date received local return) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

39091