

No. 2
12-45
17-39
X47070

State File No. 3575
Registrar's No. 173

FILED FEB 5 1947

Registration District No. 3

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(c) County St Louis
(b) City or town KOCH, MO
(c) Name of hospital or institution: KOCH HOSPITAL - KOCH, MO
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution. 12 8 DAYS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME PENNY, WILLIE

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

4. Sex MALE 5. Color or race NEGRO
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife EDDIE MAE PENNY
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased: 11 11 1898
(Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 13
If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business _____

12. Name REV. H.P. PENNY

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

14. Maiden name MATTIE DAVIS

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

16. (a) Informant HOSPITAL RECORDS

(b) Address KOCH HOSP, KOCH, MO

17. (a) BURIAL (b) Date thereof 1-26-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FRONTON CEMETERY

18. (a) Signature of funeral director Sam B. Lush

(b) Address 1-23-47

19. (a) 1-23-47 (b) Richard J. Allen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2911 & MADISON 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 20
year 47 hour 6 minute 55 A.M.

21. I hereby certify that I attended the deceased from 9-24 1946 to 1-20 1947
that I last saw him alive on 1-20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC PULMONARY TUBERCULOSIS 1 yr?
Duration _____

Due to _____
Due to 13X

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 G

23. Signature Buried Funeral (M. D. or other M.D.)
Address KOCH HOSPITAL, KOCH, MO Date signed 1-20-47

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

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.....

J.A. Green

Licensed Embalmer No. 2963

P. O. Address 295 Hanker

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.