

No. 2
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FILED OCT 27 1947
Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **913**

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: La fontaine at Scott Streets
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community Unknown
years, months or days

3. (a) PRINT FULL NAME Cleo Cecil "JACK" PENLAND

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mrs. Thelma Penland

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

7. Birth date of deceased: May 3 1894
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>53</u> | <u>5</u> | <u>19</u> | hr. _____ min. _____ |

9. Birthplace Des Moines Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Bar-Tender and Roofer

11. Industry or business _____

MOTHER FATHER {

12. Name Henry Penland

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

14. Maiden name Ora Cline

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

16. (a) Informant Henry Herbert Penland (son)

(b) Address 924 East Brower Street

17. (a) Burial (b) Date thereof 10/25/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem.

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 10/24/47 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 924 East Brower Street
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22, year 1947 hour 12: minute 30 P. M.

21. I hereby certify that I attended the deceased from Unattended by physician 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 probably chronic myocarditis

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 local registrar

Signature W. E. Handley (M. D. or other) _____

Address Springfield Mo Date signed 10/24/47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MAR 29 1948

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 James E. Kudd

Licensed Embalmer No. 2831

P. O. Address Springfield 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. NovRegistration District No. 129Primary Registration District No. 2000Registrar's No. 913

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Springfield
(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 Leo C. J. Perland3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex m
Color or
race w6. (a) Single, widowed, married,
divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____7. Birth date of deceased May 3 1947
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

(Less than one day)

53

hr. _____ min.

9. Birthplace Jawa
(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) 10-31-47 (b) M.E. Handley M.D.
(Date received local registrar) (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 _____
year 1947 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____
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 _____

Duration

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 sta-
tistically.

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) (c) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

S-34218