

FILED JUL 8 1949

STANDARD CERTIFICATE OF DEATH

State File No. 22392

BIRTH NO. _____ REG. DIST. NO. 369 PRIMARY REG. DIST. NO. 6257 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Wayne		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Wayne	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Patterson (Rural)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Patterson (Rural)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Robert c. (Last) Pentacuff			4. DATE OF DEATH (Month) (Day) (Year) June 4 1949		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 10 1890	9. AGE (In years last birthday) 59	10. IF UNDER 1 YEAR: Months 24 Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Dis. Veteran		11. BIRTHPLACE (State or foreign country) Medcoff Co. Ky	
13a. FATHER'S NAME James Pentacuff			13b. MOTHER'S MAIDEN NAME Amelia Simmons		14. NAME OF HUSBAND OR WIFE Daisy May Pentacuff
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or date of service) 1 World War		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Miss Nora Gray St Louis mo ADDRESS _____	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epileptic Convulsions		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		3533	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		=	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **6-4 - 1949**, to **6-4 - 1949**, that I last saw the deceased alive on **6-4 - 1949**, and that death occurred at **8 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE St. Jones M.D. Piedmarch Mo. (Degree or title)		23b. ADDRESS		23c. DATE SIGNED 6-7-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Bones		24b. DATE 6/7/49		24c. NAME OF CEMETERY OR CREMATORY Woods	
24d. LOCATION (City, town, or county) (State) Near Patterson Mo.		DATE REC'D BY LOCAL REG. July 2 49		REGISTRAR'S SIGNATURE Luric C. Piles 340	
25. FUNERAL DIRECTOR'S SIGNATURE William Cook		ADDRESS _____			

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

REIVED 7-7-49

Health Officer No. 4

Number 249-894

AUG 31 1949

SEP 2 1949

JUN 9 1953

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

Codex Funeral Home

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *William Cook*

Licensed Embalmer No. *3722*

P. O. Address *Richmont, Md*

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.