No. 300
10.48

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35467

BIRTH NO. 68537-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 8826

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DePaul Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Normandy
d. STREET ADDRESS (If rural, give location): NR - 6115 Emerald

3. NAME OF DECEASED (Type or Print)
a. (First): Ambrose
b. (Middle): Michael
c. (Last): Pennock

4. DATE OF DEATH (Month) (Day) (Year): Oct. 9, 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Oct. 8, 1949
9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours 20 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Theodore Oscar Pennock
13b. MOTHER'S MAIDEN NAME: Belle Lou Willman
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Theodore Pennock, 6115 Emerald

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Atelectasis bilat. congenital — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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 ☑ NO ☐

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): 1610
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 7620

22. *I hereby certify that I attended the deceased from* 8 Oct, 1949, *to* 9 Oct, 1949, *that I last saw the deceased alive on* 9 Oct, 1949, *and that death occurred at* 12 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Judy
23b. ADDRESS: 9 [illegible] Ferguson Mo
23c. DATE SIGNED: 10/12/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 10-11-49
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Cuba, Mo.

DATE REC'D BY LOCAL OCT 13 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed No Embalm

Licensed Embalmer No.....

P. O. Address.....

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

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