

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26772**
Registrar's No. **6975**

FILED **SEP 11 1953**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Arkansas b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Corning		8030
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital			d. STREET ADDRESS (If rural, give location) Rural Route		
3. NAME OF DECEASED (Type or Print) KATTIE	a. (First)	b. (Middle) LEE	c. (Last) PENTER	4. DATE OF DEATH (Month) (Day) (Year) 7-11-53	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5-1-1893	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Corning Ark		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Boyd		13b. MOTHER'S MAIDEN NAME Amanda Watson		14. NAME OF HUSBAND OR WIFE Herbert Penter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Vana Penter, Corning, Ark.			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain tumor, unverified 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.				INTERVAL BETWEEN ONSET AND DEATH Unknown
19a. DATE OF OPERATION 7/11/53	19b. MAJOR FINDINGS OF OPERATION Brain tumor				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? 217X			
22. I hereby certify that I attended the deceased from 7/9 , 19 53 , to 7/11 , 19 53 , that I last saw the deceased alive on 7/11 , 19 53 , and that death occurred at 8:30 p. m., from the causes and on the date stated above.					
23a. SIGNATURE [Signature]		(Degree or title) M.D.	23b. ADDRESS St. Lukes Hospital		23c. DATE SIGNED 7/12/53
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 7-12-53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Corning, Ark.		
DATE REC'D BY LOCAL REG. JUL 15 1953	REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Corning, Ark.

610 1 1952

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

working under my personal supervision.

Student Embalmer No.

Signed *Albert Mayfield*

Signed.....
Student Embalmer

Licensed Embalmer No. *307*

P. O. Address *St. Louis*

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

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