

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25067

State File No. ....

6651

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )		c. LENGTH OF STAY (In this place) <b>3 days</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Bapstist Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>5323A St. Louis Ave. 2069</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>James</b>		b. (Middle) <b>A.</b>		c. (Last) <b>Pennington</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 18, 1954</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>		8. DATE OF BIRTH <b>Dec. 7, 1879</b>	
9. AGE (In years last birthday) <b>74</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) <b>California, Mo.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Barber</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? <b>Am.</b>	
13a. FATHER'S NAME <b>John Pennington</b>			13b. MOTHER'S MAIDEN NAME <b>Inkown</b>			14. NAME OF HUSBAND OR WIFE <b>Mary L. Pennington</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>James Clifford Pennington 5323A St. Louis Ave.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Dis</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>acquired Anomaly Dis Insomnia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>  <b>uncertain</b>  <b>uncertain</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4200</b>					
22. I hereby certify that I attended the deceased from <b>July 14, 1954</b> , to <b>July 18, 1954</b> , that I last saw the deceased alive on <b>July 17, 1954</b> , and that death occurred at <b>12:45A</b> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Thomas W. Parker M.D.</b>				23b. ADDRESS <b>4660 Maryland</b>		23c. DATE SIGNED <b>July 19, 1954</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 20, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hills Gardens</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>	
DATE REC'D BY LOCAL REG. <b>JUL 19 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Fred C. Henke 4911 Washington Blvd</b>			

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

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**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.....  
Signature of Student Embalmer

Signed *Robert M. Murray*.....

Licensed Embalmer No. *137*.....

P. O. Address *St. Louis*.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**