Health & Welfare Public Service
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-029591
STATE FILE NUMBER

FILED SEP 8 1958 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 101

1. PLACE OF DEATH
a. COUNTY Linn
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield MO
Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McClaney Hospital
Length of stay in 1b 2 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO
b. COUNTY Linn
c. CITY OR TOWN Brookfield 0582
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 426 E Sedrick St Brookfield
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last
Myrtle F. Penhole

4. DATE OF DEATH Month Day Year
Sept 3rd 1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH May 28-1887
9. AGE (In years last birthday) 71
IF UNDER 1 YEAR Months 3 Days 6
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Shelby Linn Co. Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Geo. Monroe
13b. MOTHER'S MAIDEN NAME Carie T. Shaw
14. NAME OF HUSBAND OR WIFE Will Penhole Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 491-28-3300
17. INFORMANT Elsie Penhole Address Purdin MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Memic — INTERVAL BETWEEN ONSET AND DEATH 1 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral vascular accident — 2 mo.
DUE TO (c) Hypertension cardio vascular disease — 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443 X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) —
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year —
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8/25 / 47 to 9/3/58 and last saw her/him alive on 9/3/58
Death occurred at 9/3/58 11 3/4 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. W. Bodenhoff M.D.
22b. ADDRESS Brookfield Mo
22c. DATE SIGNED 9/5/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Sept 5 1958
23c. NAME OF CEMETERY OR CREMATORY Purdin Cemetery
23d. LOCATION (City, town, or county) (State) Purdin MO

24. FUNERAL DIRECTOR ADDRESS Bathers Funeral Home Linneus Mo
25. DATE RECD. BY LOCAL REG. 9-5-58
26. REGISTRAR'S SIGNATURE Katharine Johnson Dep

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

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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 .....

Licensed Embalmer No. 2001

P. O. Address .....

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.