

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 18 1960

60-027547

STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u>LEE</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>BROOKFIELD Mo.</u>		Length of stay in 1b <u>12 HRS.</u>		c. CITY OR TOWN <u>Ft. MADISON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PERSHING MEM. HOSP</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2705 AVE. L</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>DAVID</u> Last <u>PENROD</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>9</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-13-1924</u>	9. AGE (last birthday) <u>35</u>	UNDER 1 YEAR Months <u>8</u> Days <u>26</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>ATSF RWY</u>		11. BIRTHPLACE (City and state or country) <u>Ft. MADISON IA.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>PETER H. PENROD</u>			13b. MOTHER'S MAIDEN NAME <u>ORA SWEET</u>			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W. II</u>			16. SOCIAL SECURITY NO. <u>481-20-7254</u>		17. INFORMANT <u>MONA JOHNSTONE</u>			Address <u>FT. MADISON IA.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Massive Brain Concussion</u>						<u>10 hrs. 45 min.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Traumatic skull Fracture</u>						<u>10hrs. 45 min.</u>		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Automobile accident</u>					
20c. TIME OF INJURY Hour <u>4:30</u> m. Month, Day, Year <u>7-8-60</u>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 36 West Brookfield, Missouri</u>		20f. CITY, TOWN, OR LOCATION <u>Brookfield, Missouri</u>		COUNTY		STATE <u>IA.</u>
21. I attended the deceased from <u>July 8, 1960</u> to <u>July 9, 1960</u> and last saw her/him alive on <u>July 9, 1960</u> Death occurred at <u>3:15 am.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Dr. R. L. Ryals</u> (Dr. or title) <u>R. L. Ryals D.O.</u>				22b. ADDRESS <u>Brookfield, Missouri</u>			22c. DATE SIGNED <u>7-9-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEM.</u>		23d. LOCATION (City, town, or county) <u>Ft. MADISON IA.</u>		(State)	
24. FUNERAL DIRECTOR <u>Miller-Tillotson</u>			ADDRESS <u>MARCELINE Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-9-60</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u> ^{dep}		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 19 1960
JUL 21 1960

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

Liberman K. Tillat

Licensed Embalmer No. 4508

P. O. Address

Marcel

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.