

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008584
8584-61
STATE FILE NUMBER

AMENDED FILED APR 3 1961
Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 45-

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Newell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Newell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> Length of stay in 1b <u>Just out</u>		c. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Norway 63 North</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>SS Rd</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marydelen Penney</u>			4. DATE OF DEATH Month Day Year <u>3-15-61</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/5/900</u>
9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and State or country) <u>Nevada, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Wm Kuntz</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary A. McGeary</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>Ann Peppen, Hickory, Cal</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Throat cut by flying glass</u> DUE TO (b) <u>Bled to death</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Just out</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Norway acc. 3/15-61 Meadow view farm</u>			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>Norway Highway accident</u>	
20c. TIME OF INJURY Hour a.m. <u>11:30</u> Month, Day, Year <u>3-15-61</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Norway 63 N.</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>West Plains Newell Mo</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>about 11:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank Cook, Embalmer</u>		22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>3-17-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3/18-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Norway</u>	23d. LOCATION (City, town, or county) (State) <u>Carroll City, Mo</u>
24. FUNERAL DIRECTOR <u>Robert M. Kline</u>	ADDRESS <u>Mo 4-1-61</u>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

MAY 2 1961

APR 18 1961

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 *D. J. Roberts*

Licensed Embalmer No. 3437
P. O. Address *West Hill*

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.