

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-033820

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 121

AMENDED

FILED SEP 27 1961

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA.</u>		Length of stay in 1b <u>LIFE</u>	c. CITY OR TOWN <u>LOUISIANA</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>HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>402 N. 7th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT WAYNE PENROD</u>			4. DATE OF DEATH Month Day Year <u>SEPT 18 1961</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 4 1954</u>	9. AGE (last birthday) <u>7</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)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>LOUISIANA MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>BOBBY D PENROD</u>	13b. MOTHER'S MAIDEN NAME <u>WILLELLA CHENOWETH</u>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (Give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>BOBBY D PENROD</u> Address <u>LOUISIANA MO</u>

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>Coronary Thrombosis</u> DUE TO (b) <u>Azotemia</u> DUE TO (c) <u>Acute Nephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>4 Days</u> <u>4 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bilateral Paralytic Cataplexy - resulting from cerebral ischemia.</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 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.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>June 1958</u> to <u>Sept 18 1961</u> and last saw ^{him} alive on <u>Aug 17, 1961</u> Death occurred at <u>7:30 AM</u> on the date stated above, and to the best of my knowledge from the causes stated.			

22a. SIGNATURE <u>Ralph H. Hoyle</u> (Degree or Title)	22b. ADDRESS <u>519 W Main Bowling Green MO</u>	22c. DATE SIGNED <u>9/20/61</u>	
23a. BURIAL, CREMATION, or DISPOSAL (Specify)	23b. DATE <u>SEPT 20-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM. RFD LOUISIANA MO</u>	23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR <u>COLLIER FUNERAL SERVICE</u> ADDRESS <u>LOUISIANA MO</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 25-1961</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Callier</u>
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(Signed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Geo. M. Callier

Licensed Embalmer No. 3839

P. O. Address Louisiana

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.