

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-029547
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2230

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 1 1962

VS 300 Rev. 4/59	DATE AMENDED		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
14000					
24000					
3					
4 1					
5 1					
6					
7 0					
8 0					
9 201X					
10					
11					
12 90-0					
13					
	SHOULD READ		BY AFFIDAVIT OF		

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MEHLVILLE</u>		c. CITY OR TOWN <u>MEHLVILLE</u>	
Length of stay in 1b <u>24 yrs.</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>3626 WILL AVE</u>		d. STREET ADDRESS (If outside, give location) <u>3626 WILL AVE</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOAN DELORES PENNING</u>			4. DATE OF DEATH Month Day Year <u>JULY - 30 - 1962</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1938</u>
9. AGE (last birthday) <u>24</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months <u>6</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>CALVIN MUELLER</u>	
13b. MOTHER'S MAIDEN NAME <u>MOZELLE WILLHAUCK</u>		14. NAME OF HUSBAND OR WIFE <u>ROLAND PENNING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NIL</u>	17. INFORMANT Address <u>ROLAND PENNING 3626 WILL AVE 57604 25 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>Hodgkin's Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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 checked="" 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>Feb 6, 1960</u> to <u>present</u> and last saw her <u>alive</u> on <u>July 24, 1962</u> Death occurred at <u>1032 e-w</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Michael M. Paul, M.D.</u>		22b. ADDRESS <u>4652 MARYLAND St LOUIS</u>	22c. DATE SIGNED <u>7/31/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG-2-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mrs Hope Cem</u>	23d. LOCATION (City, town, or county) (State) <u>LEMAPY, MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Fey Funerals Home, MEHLVILLE</u>		25. DATE RECD. BY LOCAL REG. <u>8-1-62</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy, M.D.</u>

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 *Gustav W. Dietrich*

Licensed Embalmer No. 4329

P. O. Address St Louis Mo

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.