

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3404

State File No.

Registrar's No. **36**

Registration District No.

Primary Registration District No. **3046**

1. PLACE OF DEATH:

(a) County **Moniteau Co**
(b) City or town **California, Mo.** **Walker**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
603 West St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether)
In this community **Life**
years, months or days)

3. (a) PRINT FULL NAME **Walter Audrey Pennington**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. **7** years

7. Birth date of deceased. **Jan 9 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
11 29 hr. min.

9. Birthplace **California, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **Clarence Pennington**

13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Sylvia Bolin**
(City, town, or county) (State or foreign country)

15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) **burial** (b) Date thereof **Jan. 8. 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cent. California**

18. (a) Signature of funeral director **Bowlin Funeral Home**
(b) Address **California, Mo.**

19. (a) **1-9-45** (b) **H.R. Robey**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Moniteau**
(c) City or town **California, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **603 West St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **7**
year **1945** hour **7** minute **A.** M.

21. I hereby certify that I attended the deceased from **March 2** to **Jan 7**, 19**45**
that I last saw him alive on **Jan 6**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Leukemia**

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury

23. Signature **H.R. Robey** (M.D. or other)
Address **California** Date signed **1/8/46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 2-11-46

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, fact should be so stated above.