

Registration District No. 1085 Primary Registration District 7471

1. PLACE OF DEATH a. COUNTY <u>Muhlenberg</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Ky.</u> b. COUNTY <u>Muhlenberg</u>		
b. CITY (If outside corporate limits, write RURAL and give town) <u>Drehtobers Rural</u>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <u>Drehtobers</u>		IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS <u>Route 1</u>		IS RESIDENCE INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or Print) a. (First) <u>BEN</u> b. (Middle) <u>John</u> c. (Last) <u>PENROD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 9 1960</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 15, 1880</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Year: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>00</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Manuel Penrod</u>			14. MOTHER'S MAIDEN NAME <u>Mary Jane Abbott</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mable Coim Penrod Ky</u>		
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute circulatory Failure</u> MEDICAL CERTIFICATION Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b) <u>myocardial Disease</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4222</u>					INTERVAL BETWEEN ONSET AND DEATH
20. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			21a. DESCRIBE HOW INJURY OCCURRED! (Enter nature of injury in Part I or Part II of item 18.)		
21b. TIME OF INJURY <u>Hour Month, Day, Year</u> a. m. p. m.					
21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21e. CITY, TOWN, OR LOCATION		COUNTY STATE
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.					
23a. DATE SIGNED <u>3/10/60</u>	23b. ADDRESS <u>Central City Ky 19</u>		23c. SIGNATURE <u>Dr. Charles Jones</u> (Degree or title)		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/12/60</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Butler County Ky.</u>	
25a. DATE REC'D BY LOCAL REG. <u>3-15-60</u>	25b. REGISTRAR'S SIGNATURE <u>Margaret Hodge</u>		26. FUNERAL DIRECTOR <u>Parsons - Washburne - Pennell</u>		ADDRESS <u>Funeral Home 2. E. Washburne B. A.</u>