N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 25-31660

PLACE OF DEATH

County: Boone

Township: Bourbon

or Village: —

or City: —

Registration District No. 79

Primary Registration District No. 5116

Registered No.

(NO. ____, ____ St.; ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Elous Davis Jennings

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH: Nov (Month) 11 (Day), 1898 (Year)

AGE: 19 yrs. 11 mos. 13 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm Labor

BIRTHPLACE (City or town, State or foreign country): Boone Co. MO

PARENTS
NAME OF FATHER: Robt E. Jennings
BIRTHPLACE OF FATHER (City or town, State or foreign country): Boone Co MO
MAIDEN NAME OF MOTHER: Annie D. Winn
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Boone Co MO.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rolla R. Richards,

(ADDRESS) Sturgeon MO.

Filed Oct 25, 1918. E. N. Gentry REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 24 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 14th, 1918, to Oct 24th, 1918, that I last saw him alive on Oct 24th, 1918, and that death occurred, on the date stated above, at 3-40 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobular) involving both Lungs

(Duration) 0 yrs. 0 mos. 10 ds.

Contributory (SECONDARY) La Grippe

(Duration) ____ yrs. ____ mos. 14 ds.

(Signed) E. N. Gentry M. D.

Oct 25, 1918 (Address) Sturgeon Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Union Cemetery

DATE OF BURIAL: Oct 25, 1918

UNDERTAKER: M. L. Rush

ADDRESS: Centralia

WRITE PLAINLY, WITH UNFADING INK THIS IS A PERMANENT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO....., ...St.;.....Ward)

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day) 1.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month) .....(Day) 191.....(Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS