

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

16491

1. PLACE OF DEATH

County Jackson Registration District No. 899 File No. 1002
 Township Rose Primary Registration District No. 1002 Registered No. _____
 City Norfolk City (No. 3230) Charlotte St. _____ Ward _____

2. FULL NAME

(a) Residence No. 3230 Charlotte St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Corra K Jenkins</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 16 1853</u>		
7. AGE	YEARS	MONTHS
<u>66</u>	<u>6</u>	<u>0</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Salesman</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Wholesale shoe</u> (c) Name of employer <u>Brown Shoe</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Peru Indiana</u>		
10. PARENTS		
18. NAME OF FATHER <u>George Jenkins</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Berry Indiana</u>		
12. MAIDEN NAME OF MOTHER <u>Anna Day</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 16 1920

17. I HEREBY CERTIFY, That I attended deceased from 3-20-1920 to 4-16-1920, and that I last saw him alive on 4-15-1920, and that death occurred, on the date stated above, at 2:25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
82 D Hemiplegia
66 (duration) 5 yrs. mos. da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) W. K. King, M. D.
4/17/19 (Address) 104 B. 2nd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT Corra K Jenkins
 (Address) 3230 Charlotte

15. FILED 4/19, 19 20 M. M. Crowe
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill

20. UNDERTAKER W. K. King

DATE OF BURIAL April 19 1920
 ADDRESS 918 Broadway

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

