

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

Do not use this space.

36400

1. PLACE OF DEATH

County Buchanan
 Township
 City St. Joseph,

85
 Registration District No.
 Primary Registration District No. 1001
 (No. Missouri Methodist Hospital)

File No.
 Registered No. 1321
 St. _____ Ward

2. FULL NAME Mabel Angeline Jennings,

(a) Residence No. _____ St. _____ Ward Redding, Iowa,
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married,

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles T. Jennings,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 17, 1876

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	52	10	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home,
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Redding,
 (STATE OR COUNTRY) Iowa,

10. NAME OF FATHER James A. Miller,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rockbridge Co.
 (STATE OR COUNTRY) Virginia,

12. MAIDEN NAME OF MOTHER Sarah Mackey,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Rockbridge Co.
 (STATE OR COUNTRY) Virginia,

14. INFORMANT Chas. T. Jennings
 (Address) Redding, Iowa.

15. FILED 18 1929 John G. Ott.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 16, 1929

17. I HEREBY CERTIFY, That I attended deceased from _____
Nov 15, 1929, to Nov 16, 1929
 that I last saw her alive on Nov 15, 1929, and that death occurred, on the date stated above, at 8:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cholera -
126
1274
1180 (duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Diarrhea
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. Redding, Iowa

1 DID AN OPERATION PRECEDE DEATH? No DATE OF Nov 15 29
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) W. J. Tolson, M. D.

Nov 16, 1929 (Address) St Joseph, Mo

* 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Redding, Iowa, DATE OF BURIAL Nov. 18, 1929

20. UNDERTAKER Heaton-Bibale & Bowman ADDRESS 319 S. 10 St.

Funeral Home

N. B. - Every item of information should be carefully supplied. - should be stated in plain terms, so that it may be properly classified. - Exact statements - Cause of Death in plain terms, so that it may be properly classified.

11
 48
 1929

Was the acido-
sis Diabetic?

No. It was a Lactic
acidosis

TAKE THIS TO

SPENGLER'S PHARMACY

PRESCRIPTION PHARMACY

PHONES: 6-0694, 6-0695

7TH AND FRANCIS STS.

ST. JOSEPH, Mo.

NAME _____ ADDRESS _____

R_x

Headache due to vomiting
inability to retain any
of food for one week -
Dehydrated -

W. J. Schmidt

REG. No. _____

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan Registration District No. 83-
Township St. Joe Primary Registration District No. 1001 File No. _____
City St. Joe (No. _____) St. _____ Ward _____ Registered No. 1321

2. FULL NAME

Mabel Angeline Jennings
(a) Residence. No. _____ 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. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY)

14. INFORMANT _____
(Address)

15. FILED Jan 13 1929 John G. W. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 16 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Acidosis (SECONDARY)
_____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) _____, M. D.

_____, 19____ (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

SUPPLEMENTARY

69B

N. B. Every item of information should be carefully supplied and 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE.