

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.

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

Do not use this space.
Do not use
20224

1. PLACE OF DEATH

County *Deming* Registration District No. *65-1*
Township *Little River* Primary Registration District No. *8-8-62*
City *Deming* No. *1* St. *1* (Ward)

2. FULL NAME

Berthy Louise Jennings
(a) Residence. No. *1* St. *1* Ward *1*
(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
4. COLOR OR RACE *white*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *S*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *6-21-29*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 0 4

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) *Mo*

10. NAME OF FATHER *R. L. Jennings*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Lepp*
12. MAIDEN NAME OF MOTHER *Phillie Tate*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Tenn*

14. INFORMANT *B. L. Jennings*
(Address) *Centerville Mo*

15. FILED *July 8, 1930* *W. A. Martin* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-25-30*

17. I HEREBY CERTIFY, That I attended deceased from *6* *17* *1930* that I last saw him alive on *17* *1930* and that death occurred, on the date stated above, at *9:15 AM*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cholera infantum
11977 (duration) yrs. mos. *9* ds.

CONTRIBUTORY (SECONDARY) *TBA* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *TBA*
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *no*
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS *you*
(Signed) *A. R. Cooper* M. D.

June 25, 1930 (Address) *Centerville 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 *Maple Cemetery* DATE OF BURIAL *6-26-30*

20. UNDERTAKER *H. B. Smith* ADDRESS *Centerville Mo*

