

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

Do not use this space.

4174

1. PLACE OF DEATH
 County Dade Registration District No. 237
 Township _____ Primary Registration District No. 4144
 City Greenfield (No. _____) St. _____ Ward _____

2. FULL NAME Pauline Jenkins
 (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. ds.

File No. _____
 Registered No. 7

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 29-1913

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>18</u>	<u>9</u>	<u>5</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) Home 230
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Greenfield / (STATE OR COUNTRY) MO

10. NAME OF FATHER Frank Howell

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

12. MAIDEN NAME OF MOTHER Katie Duncan

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

14. INFORMANT Mrs Katie Howell (Address) Greenfield MO

15. FILED 3-10-32 EB Ball REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 4 1932

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1932, to Feb 4, 1932 that I last saw him alive on Feb 4, 1932 and that death occurred, on the date stated above, at 8:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Typhoid Fever with Terminal Lobar Pneumonia
 (duration) yrs. mos. 29 ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH at Place of Death

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) PA Powell, M. D.

, 19 (Address) Lockwood 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 Vaughn Cem DATE OF BURIAL Feb. 5 1932

20. UNDERTAKER Harrison Undertaking Co Greenfield MO ADDRESS _____

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.

W.D.S. 2
 MAR 23 1932

