

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

85

11712

1. PLACE OF DEATH

County Beechman

Registration District No.

Township

City

St Joseph Mo (No. State Hosp #2)

Primary Registration District No.

1001

File No.

Registered No.

392

St.

Ward)

2. FULL NAME

(a) Residence. No.
(Usual place of abode)

St.

Ward.

Length of residence in city or town where death occurred 13 yrs. 3 mos. 14 ds.

How long in U.S., if of foreign birth? 13 yrs. 3 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Oct 24 1870

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

61

5

26

8. OCCUPATION OF DECEASED

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

Farmer

(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)

Lincoln Co. Mo

10. NAME OF FATHER

Wm Phillips Jennings

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

Richmond Va.

12. MAIDEN NAME OF MOTHER

Lina Ann Dyer

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

Warren Co Mo

14. INFORMANT

Records State Hosp #2

(Address) St Joseph Mo

15. FILED

4-20-32 John R. Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 20 1932

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1931, to April 20, 1932 that I last saw him alive on April 20, 1932, and that death occurred, on the date stated above, at 12:55 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis (duration) yrs. 7 mos. 26 ds.

CONTRIBUTORY (SECONDARY)

Tuberculosis Left Arm
Joint Epilepsy (duration) yrs. 8 mos. - ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF 1932

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Dr Clifford Smith M. D.

(Address) State Hosp #2 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

DATE OF BURIAL

Blue Springs Mo - 22 1932

20. UNDERTAKER

ADDRESS

J W Stanley Blue Springs Mo

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.

MAY 28 1932

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