

DESD MAR 13 1939

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

6536  
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
(b) Township Springfield Primary Registration District No. 2001 Registered No. 134  
(c) City Springfield (d) Street No. Springfield Baptist Hosp. St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

BETTIE JANE JENNING S.  
(a) Residence, No. 1033 S. Douglas St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) Dec. 15-1938  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 1 28  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant  
9. Industry or business in which work was done, as saw mill, bank, etc. In home  
10. Date deceased last worked at this occupation (month and year)  11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-13-1939  
22. I HEREBY CERTIFY, That I attended deceased from 2-12-1939, to 2-13-1939.  
I last saw him alive on 2-12-1939. Death is said to have occurred on the date stated above, at about 9 A.M.  
The principal cause of death and related causes of importance were as follows:  
Broncho-pneumonia

Other contributory causes of importance:

Name of operation None Date of           
What test confirmed diagnosis?          Was there an autopsy?         

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?          Date of injury         , 19          
Where did injury occur?          (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury           
Nature of injury         

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify           
(Signed) W. H. Burkes M. D.  
(Address) 410 No. 1st St. Springfield, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
13. NAME (Father) Charles Walter Jennings  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
15. MAIDEN NAME (Mother) Juanita Mills  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okla.  
17. INFORMANT (ADDRESS) Chas. W. Jennings Springfield, Mo.  
18. BURIAL, CREMATION, OR REMOVAL (ADDRESS) Green Lawn DATE Feb 14 1939  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Burkes Springfield, Mo.  
20. FILED 2-14-39 Chas. A. George Local Registrar

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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

6586  
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
(b) Township \_\_\_\_\_ Primary Registration District No. 2001  
(c) City Springfield (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bettie Jane Jennings

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S  
(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.  
1 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-13-39

22. I HEREBY CERTIFY, That I attended deceased from 2-11-39 to 2-13-39, 1939

I last saw her alive on 2-12-39, 1939 Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia  
(Influenzae type)  
Malnutrition  
Date of onset \_\_\_\_\_

Other contributory causes of importance: 11W

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.

(Address) Springfield Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT

