

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

17403
 Do not use this space.

791
 1008

4937

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.

1. PLACE OF DEATH **St. Louis Mo** JUN 12 1939

(a) County **St. Louis** Registration District No. **1**
 (b) Township **St. Louis** Primary Registration District No. **1**
 (c) City **St. Louis** (d) Street No. **City Ave #1** 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 **3** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **GLENN JERNIGAN**

(a) Residence, No. **3741 St Ferdinand** St. **11** (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 **male** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 22, 1915**

7. AGE YEARS **23** MONTHS **9** DAYS **8** IF LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**

9. Industry or business in which work was done, as saw mill, bank, etc. **nil**

10. Date deceased last worked at this occupation (month and year) **nil** 11. Total time (years) spent in this occupation **nil**

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

FATHER 13. NAME **CLAUDE JERNIGAN**

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

MOTHER 15. MAIDEN NAME **MAE TRAYLOR**

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

17. INFORMANT **ELBERT JERNIGAN**
 (ADDRESS) **3741 St Ferdinand St, St Louis**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Central City Ky** DATE **May 30 39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Wm W. Brown 4259 Lindbergh Blvd**

20. FILED **MAY 31 1939** **J. D. [Signature]** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5 30 1939**

22. I HEREBY CERTIFY, That I attended deceased from **March 30 1939**, to **May 20 1939**.
 I last saw him alive on **May 30 1939**. Death is said to have occurred on the date stated above, at **4:10 a.m.**
 The principal cause of death and related causes of importance were as follows:

Bronchopneumonia (post-operative) Date of onset **5/26/39**

8/10

Other contributory causes of importance: **Old back injury 1931**
operation for mechanical pressure on the spinal cord
 Name of operation **Tamponade** Date of **5/25/39**
 What test confirmed diagnosis? **no** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **no** Date of injury **no**, 19.....
 Where did injury occur? **no** (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **no**
 Nature of injury **no**

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify **no**
 (Signed) **William H. Collins**, M. D.
 (Address) **St Louis City 2nd #1**
St Louis Mo

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Howard F. Rowla*

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.