

OCT 23 1939

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

32252
Do not use this space.

1. PLACE OF DEATH

(a) County Dade Registration District No. 237
(b) Township Sac Primary Registration District No. 411114 Registered No. _____
(c) City Greenfield Mo (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

532 LEWIS R. JENNINGS
(a) Residence, No. Greenfield Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary E. Jennings
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 6 1868
7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
70 10 1

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 11 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept 5 1939 to Sept 11 1939
I last saw him alive on Sept 10 1939. Death is said to have occurred on the date stated above, at 6:11 A. M.
The principal cause of death and related causes of importance were as follows:

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

apoplexy
J. J. ...
Date of onset _____
Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sheridan Mo Missouri

FATHER 13. NAME Wm. Jennings 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Sarah Madden 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Mary E. Jennings Greenfield Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Fullerton Cem. DATE Sept. 9 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Ward Greenfield Mo

20. FILED _____ 19. _____ Local Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No
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) W. O. Corigan, M. D.
(Address) Greenfield Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 6,

District File Number 108A-2131

Date Filed OCT 20 1939

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.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32252

Do not use this space.

1. PLACE OF DEATH
 (a) County Dade Registration District No. 237
 (b) Township Greenfield Primary Registration District No. 4144
 (c) City Greenfield (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 Lewis T. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-6-1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 16 1

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

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) Shelburne Vermont

FATHER 13. NAME Wm Jennings
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Sarah Madden
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Mary E. Jennings
Greenfield mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Interred DATE Sept 9 1939

19. FUNERAL DIRECTOR (ADDRESS) J. W. Ward
Greenfield mo

20. FILED 11-2- 1939 E. L. Wier
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 11 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 5 1939 to Sept 11 1939
 I last saw her alive on Sept 10 1939. Death is said to have occurred on the date stated above, at 11 P.M.
 The principal cause of death and related causes of importance were as follows:
apoplexy

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ 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) H. O. Cowan M. D.
 (Address) Greenfield mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-32252