

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

32287  
 Do not use this space.

OCT 19 1939

**1. PLACE OF DEATH**

(a) County Wainess 2 Registration District No. 254  
 (b) Township Marion Primary Registration District No. 5258  
 (c) City ..... (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME**

Charles F. 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 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) Aug 6 - 1863

7. AGE YEARS MONTHS DAY If LESS than 1 day, ..... hrs. or ..... min.  
76 0 8

OCCUPATION 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. Farmer  
 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) Cinn. Ohio

FATHER 13. NAME Ephraim Jennings  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

MOTHER 15. MAIDEN NAME Sarah Ann Gibbs  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

17. INFORMANT (ADDRESS) Marie Gerlach  
Ballston Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Civil Bend DATE Aug 16, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ed Groner  
Attorneysburg Mo.

20. FILED Sept 10 1939 Van C. Sutton  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 14th, 1939, to Aug 14th, 1939.  
 I last saw him alive on Aug 14th, 1939 Death is said to have occurred on the date stated above, at 7:30 P.M.  
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis.  
Chronic Valvular disease heart  
 Date of onset  
 Other contributory causes of importance:  
Nephritis.

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) Fred W. Wilson, M. D.  
 (Address) Winston, Mo.

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.

922

RECORDED  
District No. 11,  
District No. 1039-1378  
Date Filed OGT 17 1935

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 G. S. Gromer.  
Licensed Embalmer No. 2857  
P. O. Address Pattonburg, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con  
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

32287 X  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Davess Registration District No. 954  
 (b) Township Marron Primary Registration District No. 6358 Registered No. 17  
 (c) City..... (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 Chas. F. Jennings  
 (a) Residence, No. .... St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8 (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.  
76 0 8

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)

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

MOTHER 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.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-14, 1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to....., 19.....  
 I last saw h..... alive on....., 19..... 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:  
Chronic Myo Carditis  
Chronic Valvular Disease  
Heart  
 Date of onset 12/1

Other contributory causes of importance:  
Nephritis Chronic

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 Fred. K. Wilson, M. D.  
 (Signed) Winston (Address) Winston

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESENTED.  
 Every item of information should be carefully checked and corrected before being supplied. AGE should be stated EXACTLY. PHYSICAL CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

Local Registrar.

S-32287