

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days) Don't know

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Don't know
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME

Charles Ross Teninty
Jack Kelly 1400

3. (b) If veteran name was no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 22 1939
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 9-55 to 6 1939;
I am a physician lawyer dentist minister other none
I certify that the death occurred on the date and hour stated above.

Immediate cause of death: Extremes, cerebral, and interstitial cerebral hemorrhage fracture of the skull.
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 144 lb

Major findings: Of operations _____

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (Specify) Don't know
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ County _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? _____ (Specify type of place) _____ (Specify type of injury)

23. Signature Victor H. Waters (M. D. or other) _____
Address K.C. Mo Date signed _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Hester E. Don't know 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 15, 1892 (Month) (Day) (Year)

8. AGE: Years 43 Months 10 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Springfield Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Musician

11. Industry or business Music

12. Name James Teninty

13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name Josephine Gova

15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hester E. Teninty

(b) Address Neola, Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/39 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Carroll Thompson

(b) Address 3024 Forest

19. (a) Dec 29, 1939 (Date received local registrar) (b) unimpaired (Registrar's signature)

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

See affidavit # 267.

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 *E. P. Casey*
Licensed Embalmer No. *2972*
P. O. Address *30247 road*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4922

1. PLACE OF DEATH: Jackson
(a) County _____
(b) City or town Kansas City
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community unknown years, months or days

3. (a) PRINT FULL NAME Charles Ross Teninty
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hester E. Teninty
6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased February 15 1898
(Month) (Day) (Year)

8. AGE: 41 Years 10 Months 7 Days If less than one day _____ hr. _____ min.

9. Birthplace Springfield Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Miss. Can.

11. Industry or business Missis.

MOTHER FATHER { 12. Name James Teninty
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

{ 14. Maiden name Josephine Boyd
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hester E. Teninty
(b) Address Neola, Iowa

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Dec 29 1939 (b) M. M. Browne
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

~~S-42512~~

S-42513

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.