

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

Do not use this space.

14805

**1. PLACE OF DEATH**

County Dunklin Registration District No. 2  
 Township 7 Primary Registration District No. 5-4041  
 City Halecomb (No. 7) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. Advance Mo. RFD St. \_\_\_\_\_ Ward \_\_\_\_\_

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Clarence Jennings</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1-24-1906</u>		
7. AGE	YEARS	MONTHS
	<u>34</u>	<u>2</u>
		DAYS
		<u>23</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-17-1940

22. I HEREBY CERTIFY, That I attended deceased from April 8, 1940, to April 17, 1940

I last saw her alive on 4/17, 1940. Death is said to have occurred on the date stated above, at 9:40 a.m.

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

Acute Bright Disease Date of onset unknown

Other contributory causes of importance:  
Suppurative Pleurisy

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	0
13. NAME <u>J. R. Fowler</u>	0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	0
15. MAIDEN NAME <u>Ira Blue</u>	0
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	0
17. INFORMANT (ADDRESS) <u>Clarence Jennings Advance, Mo.</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Pleasant Grove</u> DATE <u>4-18</u> , 19 <u>40</u>	
19. UNDERTAKER (ADDRESS) <u>Childs Undert. Co. Bloomfield, Mo.</u>	
20. FILED <u>5-10-40</u> 19 <u>40</u> <u>J. Anderson</u> Registrar.	

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

What test confirmed diagnosis lab. Was there an autopsy? yes

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) John E. Cochran, M. D.  
 259 (Address) Halecomb

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 imp. it.

130

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number 540-10

Date Filed 5/16/40

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: \_\_\_\_\_

*Erwin Cooper*

Licensed Embalmer No. 4119

P. O. Address Bloomfield, Mo.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14805-7  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 286

Primary Registration District No. 540413

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Falcone  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Alta Jennings

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 34 Months 2 Days 23 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

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

10. Usual occupation  
11. Industry or business  
MOTHER FATHER { 12. Name  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (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 4 day 17 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death acute Bright's Disease Duration \_\_\_\_\_  
Due to Following chronic Bright's Disease  
Due to \_\_\_\_\_

Other conditions Uremic Poisoning (Include pregnancy within 3 months of death)

Major findings: Of operations 131 Of autopsy \_\_\_\_\_

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) \_\_\_\_\_  
(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 John E Cochran (M. D. or other) \_\_\_\_\_  
Address Falcone Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

S-14805