

Registration District No. **244**

Primary Registration District No. **5388**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Dallas Co.**
 (b) City or town **Rural Jasper T.P.**
 (If outside city or town limits, write "RURAL" and name of township)
 (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 **55 yrs.**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Dallas**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **P.F.D. 1**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **7**
 year **1940** hour **4** minute **25** A.M.
 21. I hereby certify that I attended the deceased from
11-3, 19**40**, to **11-7**, 19**40**;
 that I last saw him alive on **11-7**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death
acute myocardial infarction **5 weeks**
 Due to **(?)**
 Due to **59**

Other conditions **Diabetes Mellitus (?)**
 (Include pregnancy within 5 months of death)

Major findings:
 Of operations **None**
 Of autopsy **None**

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME **Lucie Jennings**
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **H. E. Jennings** 6. (c) Age of husband or wife if alive **58** years
 7. Birth date of deceased **June 24, 1884**
 (Month) (Day) (Year)

8. AGE: Years **56** Months **4** Days **11** If less than one day
 hr. _____ min. _____

9. Birthplace **Dallas Co Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **J. M. McWey**
 13. Birthplace **U.S.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Sarah Barclay**
 15. Birthplace **Dallas Co Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **L. E. Jennings**
 (b) Address **Rural Mo.**

17. (a) **Burial** (b) Date thereof **11/9/40**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Ballas Cem.**

18. (a) Signature of funeral director **Pulver**
 (b) Address **Lebanon Mo.**

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

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?
0/55 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature **R. E. Farrell** (M. D. or other) **1240**
 Address **Buffalo, Mo** Date signed **11-9-40**

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.

RECEIVED

District Health Officer No. 7,

District File Number 12-40-1738

Date Filed 12-11-40

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 _____

S. R. Palmer

Licensed Embalmer No. 2208

P. O. Address Leflore Mo.

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. 38672

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 244

Primary Registration District No. 6338

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Garner
(c) Name of hospital or institution: Rural
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas
(c) City or town Plad P. R. 1
(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.

3. (a) PRINT FULL NAME Susie Jennings

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. 6-24-1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 4 Days 11 If less than one year _____ hr. _____ min.

9. Birthplace Dallas Co
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Palmer funeral home

(b) Address Lebanon mo

19. (a) 11-15-40 (b) Mrs C. C. Reed
(Received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month 11 day 7
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 _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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 R. E. Harrell (M. D. or other) _____

Address Buffalo mo Date signed _____

SUPPLEMENTAL COPY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—FEMALE PERMANENT RECORD

