

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

Registration District No. **318 317**

Primary Registration District No. **4192**

Registrar's No. _____

1. PLACE OF DEATH
 (a) County **GREENE**
 (b) City or town **Springfield Republic**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Republic Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **None**
 (Specify whether
 In this community **30 Years**
 years, months or days)

3. (a) PRINT FULL NAME **Josephine Estella Jenkins**

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 **Married**

6. (b) Name of husband or wife **David N. Jenkins** 6. (c) Age of husband or wife if alive **78** years

7. Birth date of deceased **July 2 1867**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	7	21	hr. _____ min. _____

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

10. Usual occupation **House Wife**

11. Industry or business _____

12. Name **John Wynn**

13. Birthplace **Mo. D**
(City, town, or county) (State or foreign country)

14. Maiden name **Naney Wynn**

15. Birthplace **Mo. D**
(City, town, or county) (State or foreign country)

16. (a) Informant **Emmitt Jenkins**

(b) Address **1611 W. Olive Springfield**

17. (a) **Burial** (b) Date thereof **2/26/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn (Cem)**

18. (a) Signature of funeral director **Dunn Funeral Home**

(b) Address **Springfield, Mo.**

19. (a) **Mar 8** (b) **Mrs Bertha Nance**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **39**

(a) State **Missouri** (b) County **Greene**

(c) City or town **Republic, Mo.**
(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.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **24**
year **1941** hour **2** minute **45** A. M.

21. I hereby certify that I attended the deceased from **Dec 1st 1940**
_____, 19____, to **Feb 24 1941**
that I last saw her alive on **Feb. 24 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death
Peritonitis
Due to **Locked bowel**

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?
2 While at work? **2** (Specify type of place)
(e) Means of injury _____

23. Signature **A. L. Little** (M. D. or other)
Address _____ Date signed _____

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

RECEIVED

Greene County Health Office,

County File No. 41-4-41

Date: 4/21/41

122R

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, fact should be so stated above.

Registration District No. 317

Primary Registration District No. 4192

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Republic
(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 _____
years, months or days

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Prophine Estella Jenkins
3. (b) If veteran name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24
year 1941 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.

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 (Month) (Day) (Year)

Immediate cause of death Pneumonitis Duration _____

8. AGE: Years 73 Months 7 Days 21
If less than one day hr. min.

Due to Locked Bowel
Due to unknown

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

10. Usual occupation

11. Industry or business

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)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

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 [Signature] (M. D. or other)

Address Republic, Mo. Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

1941
S-10653