

FILLED OCT 20 1941

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

31239

Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 180  
 (b) Township Delta Primary Registration District No. 5175  
 (c) City Delta or (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

(a) Residence, No. Maryrie Jenkerson St. Delta, Mo.  
 (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 male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) infant  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF infant  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23 - 41  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, 4 hrs. or min.  
 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.  
 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) Delta, Mo.  
 FATHER 13. NAME Buford Jenkerson  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chaffee Mo.  
 MOTHER 15. MAIDEN NAME Barbara Foster  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delta Mo.  
 17. INFORMANT (ADDRESS) Wm Foster Delta Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Rayon Cem DATE 9/23/41  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Ruppenthal Delta Mo.  
 20. FILED \_\_\_\_\_ 19 \_\_\_\_\_  
275 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 23, 1941

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1941, to same, 1941  
 I last saw him alive on Sept 23, 1941 Death is said to have occurred on the date stated above, at 9 A m.  
 The principal cause of death and related causes of importance were as follows:

Premature  
6 mo 59

Other contributory causes of importance:  
mother had a fall  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? accident Date of injury Sept 23, 1941  
 Where did injury occur? at her home  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury mother fell off  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Wm Ruppenthal M. D.  
 (Address) Allenville Mo

Exact statement of OCCUPATION is very important.

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**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31239

Registration District No. 130

Primary Registration District No. 5175

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(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)

3. (a) PRINT FULL NAME

Majorie Jenkerson

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 23, 1941  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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) \_\_\_\_\_ (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) Nov 1, 1941 (b) Mrs Mrs Stecker  
(Date received local registrar) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 23 Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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 \_\_\_\_\_

Duration \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-31239-1941