

1. PLACE OF DEATH

(a) County Boone
(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State 10
(b) County 1
(c) City or town 0
(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 _____ 0

3. (a) PRINT FULL NAME AGNES JEWELL 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 Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased 7 11 27
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
15 3 26 hr. min.

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

10. Usual occupation School Child

11. Industry or business

MOTHER FATHER

12. Name Fred M. Jennings
13. Birthplace Boone Co Mo
(City, town or county) (State or foreign country)
14. Maiden name Nettie Jennings
15. Birthplace Boone Co Mo
(City, town or county) (State or foreign country)

16. (a) Informant Fred M. Jennings
(b) Address Centralia Mo

17. (a) Burial (b) Date thereof 11/19-1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Centralia Mo Jew

18. (a) Signature of general director _____
(b) Address Centralia Mo

19. (a) 11/9-1942 (b) Chas. S. Wright
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7th
year 1942 hour 11 minute 15 P M.

21. I hereby certify that I attended the deceased from Nov 6
1942 to Nov 7 1942
that I last saw her alive on Nov 7 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Central Pneumonia
Duration 3 days

Due to 108
Due to Conjunctival Haemorrhage

Other Exhaustion (partially)
(Include pregnancy within 3 months of death) Subsiding tension

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)
(c) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Centralia Date signed 11-8-42

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

10
1
0

5-17-39
X 29484

1237

STATEMENT BY LICENSED EMBALMER

USE - USE ONLY

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 *M. Jones*
Licensed Embalmer No. 4313
P. O. Address Centerville 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36639

Registration District No. 37

Primary Registration District No. 4049

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Boone
 (b) City or town Centralia
(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 Died at home
(Specify whether
 In this community Life
years, months or days)

3. (a) PRINT FULL NAME Agnes Jewell 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 S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: July (Month) 11 (Day) 1942 (Year)

8. AGE: Years 15 Months 3 Days 10 min. mo.
If less than one day

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
 (c) City or town Centralia
(If outside city or town limits, write "RURAL")
 (d) Street No. Home not numbered
(If rural, give location)
 (e) Citizen of foreign country? Born in U.S.A. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 19 Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____	Duration _____
Due to _____	

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?

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

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

WRITE PLAINLY - USE FADING BLACK INK - MAKE A PERMANENT RECORD

S-36639

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