

FILED MAR 25 1943

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 2434

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis

(c) Name of hospital or institution: St. Joe. Hosp. Hospital
(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 Mo. (b) County St. Louis

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1407 E. 17th St.
(If rural, give location)

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

3. (a) PRINT FULL NAME WILLIAM JENKINS

3. (b) If veteran, name war World War (c) Social Security No. 702-15-0157

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Josephine Jones 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased April 17 - 1897
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|----------|----------------------|
| | <u>49</u> | <u>11</u> | <u>0</u> | _____ hr. _____ min. |

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

10. Usual occupation Storeman

11. Industry or business St. Joe. Hosp. A.R.P.O.

12. Name Anthony Jenkins

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

14. Maiden name Elara (unknown)

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

16. (a) Informant Josephine Jenkins

(b) Address Kansas City, Mo.

17. (a) Buried (b) Date thereof 3-16-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director W. J. Braddock

(b) Address 6677 Clayton Rd.

19. (a) MAR 14 1943 (b) W. J. Braddock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13 year 1943 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from 2/27/43, 19____, to 3/13/43, 19____; that I last saw him alive on 3/13/43, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Thrombosis Post-Operative Thrombocytopenia Cerebral Head Swelling

Duration: _____

Due to: 13

Other conditions (Include pregnancy within 3 months of death): 62

Major findings: Of operations Toxic Adenomatous Thyroid

Of autopsy: None

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 W. J. Braddock (M. D. or other) _____
Address St. Joe. Hospital Date signed 3/13/43

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

MOTHER FATHER

NOV 24 1947

MAR 29 1948

NOV 15 1947

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.