

No. 2
1-542
5-17-39
X3227

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28055
Registrar's No. _____

FILED SEP 10 1943
Registration District No. 3054

Primary Registration District No. 3054

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln
(c) City or town Edia
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Rt 1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Omer Delmer Jennings

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bessie Rue Palmer Jennings 6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased July 22 1878 (Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 19 If less than one day 0 min.

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

10. Usual occupation Farmer

11. Industry or business General Farming

12. Name Mr Israel Jennings

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

14. Maiden name Mary Cordelia Logan

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

16. (a) Informant Mrs Bessie Palmer Jennings

(b) Address Patoka Ill

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

(c) Place: burial or cremation Patoka Ill

18. (a) Signature of funeral director Jennings

(b) Address Louisiana Mo

19. (a) 8/31-43 (b) Jennings (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31 year 1943 hour 2 minute 45 P.M.

I hereby certify that I attended the deceased from 8-28-43 to 8-31-43 19____, that I last saw him alive on 8-31-43 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Arteriosclerosis + hypertension

Due to _____

Other conditions None (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(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? No (Specify type of place) (Means of injury)

23. Signature Jennings (M. D. or _____)

Address Louisiana Mo Date signed 8-31-43

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

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

RECEIVED

District Health Officer No. 10

District File Number 9-43-1474

Date Filed SEP 9 1943

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.....

George O. Wagner, Registered Apprentice No.....
working under my personal supervision.

Signed George O. Wagner

Licensed Embalmer No. 3773

P. O. Address Louisiana, 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.