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41069

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 22 1943
1949

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 5024

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

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 1/2 WEEKS
(Specify whether YEARS (years, months or days))

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 78

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3523 WALNUT STREET 8
(If rural, give location)

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

3. (a) PRINT FULL NAME MRS. ELEANOR BROCK JENKINS

3. (b) If veteran, name war No
3. (c) Social Security No. none

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced, DIVORCED 3
6. (b) Name of husband or wife MR. W. B. JENKINS
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased AUGUST 22 1900
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
43	3	5	hr. _____ min.

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

10. Usual occupation AT HOME

11. Industry or business

MOTHER FATHER {
12. Name Wm. S. Brock
13. Birthplace KENTUCKY
14. Maiden name THERESA HANSEN
15. Birthplace TEXAS
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. J. E. SANBORN

(b) Address CORPUS CHRISTI TEXAS

17. (a) BURIAL (b) Date thereof Nov 29 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. MORIAH CEMETERY

18. (a) Signature of funeral director O. H. Newcomer, Sons
(b) Address 1401 BRUSH GREEN BLVD.

19. (a) 11-29-43 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 27TH
year 1943 hour 9 minute 30 A.M.

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

Immediate cause of death
Right cerebral hemorrhage

Due to Hypertension

Due to Cause unknown

Other conditions: --- (17)
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy As above

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 J. D. Smith (M. D. or other)
Date signed 11-27-43
By: Dr. J. D. Smith, M.D. Pathologist, St. Joseph R.H., Mo.

MAY 22 1945

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 Emile W. Calhoun

Licensed Embalmer No. 3506

P. O. Address Ke 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.