

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10449

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 329

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 yrs 1 mo 29 days
In this community 12 years 1 month 29 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 528 E. Longview
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes; name country 0

3. (a) PRINT FULL NAME Earl Leon Jenkins

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

4. Sex Male 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. 10-15-1912
(Month) (Day) (Year)

8. AGE: Years 31 Months 5 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Harrison Jenkins
13. Birthplace Popas Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mama Strang
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs H. Jenkins
(b) Address Independence Mo

17. (a) Removal (b) Date thereof 3-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Independence, Mo

18. (a) Signature of funeral director W. G. Harrison
(b) Address Independence Mo

19. (a) 3-20-44 (b) Earl Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 19
year 1944 hour 6 minute 0 M.

21. I hereby certify that I attended the deceased from 3/15 1944 to 3 1944
that I last saw him alive on 3/19 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary T.B. Duration 2 yrs

Due to _____
Due to _____

Other conditions Epilepsy 15 yrs
(Include pregnancy within 3 months of death)

Major findings: 13 ft
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Earl Jenkins (M. D. or dentist)
Address State Hospital No 2 Date signed 3-19-44

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

MOTHER FATHER

1233

(Licensed Embalmer's Statement on Reverse Side) St Joseph Mo

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 *Floyd C. Carson*
Licensed Embalmer No. *4199*
P. O. Address *Independence*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.