

FILED SEP 8 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2374

1. PLACE OF DEATH:

(a) County St. Louis,

(b) City or town St. Louis,  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Anthony's Hospital.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 107

(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL") 17

(d) Street No. #4012 Delmar Blv'd.,  
(If rural, give location) 9/19

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Dr Dwight L. Jennings.

3. (b) If veteran, name war None.

3. (c) Social Security No. None.

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

6. (b) Name of husband or wife Alice Garrison Jennings, alive 28. years

6. (c) Age of husband or wife if deceased \_\_\_\_\_ years

7. Birth date of deceased January 17, 1902.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

42. 7. 6. hr. min.

9. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation Physician... M.D.

11. Industry or business \_\_\_\_\_

12. Name Dr M. Dwight Jennings.

13. Birthplace Marion Co., Illinois.  
(City, town, or county) (State or foreign country)

14. Maiden name Lora Loyce.

15. Birthplace Clinton Co., Illinois.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Alice G. Jennings.

(b) Address 4012 Delmar Blv'd.,

17. (a) Burial. (b) Date thereof 8/26/44.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.,

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address #7233 Delmar Blv'd.,

19. (a) AUG 25 1944 (Date received local registrar)

J. F. Bueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23  
year 1944 hour 12 minute 05 P.M.

21. I hereby certify that I attended the deceased from July 12, 1944 to Aug 23, 1944  
that I last saw him alive on Aug 23, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Heart Disease, 24YB,  
Chronic Nephritis, Secondary

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Includes pregnancy within 3 months of death) 12/21

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? \_\_\_\_\_ (Specify type of place)

23. Signature R.V. Paurel (M. D. \_\_\_\_\_)  
Address 3720 Washington Date signed 8-23-44

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8411

Dr. R. V. Powell.  
3720 Washington Ave.,  
JE: 6853.

**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 Bradford A. Miles  
Licensed Embalmer No. 2901  
P. O. Address University City

**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.**