

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15894**
Registrar's No. **2109**

FILED JUN 1 1945/49

Registration District No. _____ Primary Registration District No. **1002**

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:
3303 East 9th Street
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3303 East 9th Street**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **JULIA ANN HENNINGTON**
 3. (b) If veteran, name war ******* no**
 3. (c) Social Security No. ******* none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **15th**
 year **1945** hour **3:** minute **A.** M.

4. Sex **FEMALE** / 5. Color or race **White**
 6. (a) Single, widowed, married, divorced, widowed **2**
 6. (b) Name of husband or wife **Charles R. Hennington**
 6. (c) Age of husband or wife if alive ********* years
 7. Birth date of deceased **November 13, 1859**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Dec 1942 to May 15, 1945
 that I last saw h. **alive on May 15, 1945**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Myocardial decompensation**
 Duration **3 yrs**

8. AGE: Years **85** Months **6** Days **2**
 If less than one day hr. _____ min. _____

Due to _____
 Due to _____

9. Birthplace **Crystal Springs Miss.**
(City, town, or county) (State or foreign country)

Other conditions **932**
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**
11. Industry or business **Retired**

Major findings:
 Of operations _____
 Of autopsy _____

12. Name **John W. Crawford**
13. Birthplace **Crystal Springs, Miss.**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Buie**
15. Birthplace **Crystal Springs Miss.**
(City, town, or county) (State or foreign country)

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 _____

16. (a) Informant **Mrs. D. C. Mills (Daughter)**
(b) Address **3303 East 9th. K.C. Mo.**

23. Signature **C. P. Rees, M.D.**
 Address **3303 E. 12th** Date signed **5-12-45**

17. (a) Removal **5-15-45** **(b) Date thereof**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Crystal Springs, Miss.**

18. (a) Signature of funeral director **Mrs. C. L. Forster**
(b) Address **918-920 Brooklyn, K.C. Mo.**

19. (a) 5-15-45 **(b) Geraldine Holm**
(Date received local registrar) (Registrar's signature)

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

1000

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.....

Joe B. Yoder

Licensed Embalmer No..... *4173*

P. O. Address..... *918 Brooklyn*

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:

K.C. Mc