

FILED JUN 5 1945

Registration District No. _____

Primary Registration District No. 3016

Registrar's No. 117

1. PLACE OF DEATH: *Miller, Cole*

(a) County _____

(b) City or town *Rural* (If outside city or town limits, write "RURAL")

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

(d) Length of stay: In hospital or institution *17 days* (Specify whether years, months or days)

In this community *Life*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Miller*

(c) City or town *Rural* (If outside city or town limits, write "RURAL")

(d) Street No. *Welman, R # 1* (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME *MINNIE JENKINS*

3. (b) If veteran, name war *no*

3. (c) Social Security No. *no*

4. Sex *Female* 5. Color or race *white*

6. (a) Single, widowed, married, divorced *Married*

(b) Name of husband or wife *Arthur Jenkins*

6. (c) Age of husband or wife if alive *52* years

7. Birth date of deceased *Aug 15 1895*

(Month) (Day) (Year)

8. AGE: Years *49* Months *9* Days *1*

If less than one day hr. _____ min. _____

9. Birthplace *Welman - Mo.*

(City, town, or county) (State or foreign country)

10. Usual occupation *House Keeper*

11. Industry or business *Farming*

12. Name *John Witt*

13. Birthplace *Jacksonia, Mo.*

14. Maiden name *Ellie Linters*

15. Birthplace *Missouri*

16. (a) Informant *Arthur Jenkins*

(b) Address *Welman Mo*

17. (a) *Burial* (b) Date thereof *5-18-45*

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Welman, Mo*

18. (a) Signature of funeral director *C. L. Casey*

(b) Address *Wria Mo*

19. (a) *5-22-45* (b) *Norma Richter*

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* day *16*

year *1945* hour _____ minute *8:20 P.M.*

21. I hereby certify that I attended the deceased from *4-28* 19*45* to *5-16* 19*45*

that I last saw *her* alive on *May 16* 19*45*

and that death occurred on the date and hour stated above.

Immediate cause of death *Cancer Pancreas*

Duration *1 yr*

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy *yes*

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 *Edw Mansur* (M. D. or other) _____

Address *Jefferson City Mo* Date signed *5-21-45*

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

16
5
4

11

11

894

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 6-4-45

EX-8
M-2

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 Chasey

Licensed Embalmer No. 2694

P. O. Address Brea - Cal.

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.