

FILED JUN 19 1945
Registration District No. 170

Primary Registration District No. 3026

State File No. _____
Registrar's No. 130

1. PLACE OF DEATH:

(a) County JACKSON

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

(c) Name of hospital or institution: VAILE SANITARIUM (1)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 YEAR, 2 MOS.
(Specify whether years, months or days)

In this community 59 YEARS

3. (a) PRINT FULL NAME MISS STELLA FRANCES 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 SINGLE

6. (b) Name of husband or wife ---

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

7. Birth date of deceased NOVEMBER-4-1861
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>6</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation SCHOOL TEACHER

11. Industry or business RETIRED N.C. SCHOOLS

MOTHER FATHER

12. Name BENJAMIN JENKINS

13. Birthplace UNKNOWN SOUTH CAROLINA
(City, town, or county) (State or foreign country)

14. Maiden name FRANCES WILES

15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant MRS FRANCES ROMINE

(b) Address 3001 BALES AVE KANSAS CITY, MO.

17. (c) REMOVAL (Burial, cremation, or removal) (b) Date thereof MAY 9 1945
(Month) (Day) (Year)

(c) Place: burial or cremation WABASH INDIANA

18. (a) Signature of funeral director D.H. Williams, son

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 5-9-1945 (Date received local registrar?) (b) JAMIE W. ROSS (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

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

(d) Street No. 3001 BALES AVENUE (8)
(If rural, give location)

(e) Citizen of foreign country? NO (1) (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 8TH
year 1945 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan, 1945 to May 8, 1945
that I last saw her alive on May 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Septic 14 day

Due to Pylitis

Due to Chronic Cystitis chronic

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 12/3/45

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 J. B. Harker (M. D. or other)

Address Independence Mo. Date signed May 9

1163

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

18
4
4

12-1
1st National Bank Bldg.
Dubuque, 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 Emile M. Colborn

Licensed Embalmer No. 3506

P. O. Address KC 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.