

Registration District No. 57 Primary Registration District No. 5204 Registrar's No. 4

1. PLACE OF DEATH:  
 (a) County CARROLL  
 (b) City or town BOSWORTH MO Rural, Boenford  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO (b) County CARROLL 17  
 (c) City or town BOSWORTH Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. North East Bosworth mo  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES HENRY JENNINGS  
 3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex M 5. Color or race w  
 6. (b) Name of husband or wife deceased  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 12 1865  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept day 30  
 year 1945 hour 7 minute 05 A.M.  
 21. I hereby certify that I attended the deceased from Sept 21 to Sept 30, 1945  
 that I last saw him alive on Sept 27, 1945  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Memoraboy of Brain  
Nephritis

8. AGE: Years Months Days If less than one day  
80 6 18 hr. 1 min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace Jersey City I 44 1  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation FARMER

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
 12. Name WILLIAM H. JENNINGS  
 13. Birthplace UNKNOWN 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name SARAH SUSAN TOMLIN  
 15. Birthplace UNKNOWN 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant ELMER WRIGHT  
 (b) Address BOSWORTH MO  
 17. (a) BURIAL (b) Date thereof 10-2-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
 (c) 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)  
 \_\_\_\_\_ (2) Means of injury \_\_\_\_\_

(c) Place: burial or cremation DE WITT CEMETERY  
 18. (a) Signature of funeral director David J. Edwards  
 (b) Address Bosworth mo  
 19. (a) Sept 30 (b) Pearl Koch  
 (Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. or other)  
 Address Bosworth mo Date signed [Signature]

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

MOTHER FATHER

1408

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

*David J. Edwards*

Licensed Embalmer No.

*3265*

P. O. Address

*Bosworth 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. oct  
Registrar's No. 4

Registration District No. 57 Primary Registration District No. 5204

1. PLACE OF DEATH:  
(a) County Carell  
(b) City or town Rockford Twp Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

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

3. (a) PRINT FULL NAME Charles H. Jennings  
3. (b) If veteran, name war..... (c) Social Security No. 8

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11 of day 12  
year 1944 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

Chronic Nephritis  
Due to.....  
Due to.....

7. Birth date of deceased mar 12 1866  
(Month) (Day) (Year)  
8. AGE: Years 80 Months..... Days..... If less than one day..... hr..... min.

Other conditions..... (Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....  
13/15

9. Birthplace..... (City, town, or county) (State or foreign country)  
10. Usual occupation.....  
11. Industry or business.....  
12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (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) (Means of injury).....

16. (a) Informant.....  
(b) Address.....  
17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)  
(c) Place: burial or cremation.....  
18. (a) Signature of funeral director.....  
(b) Address.....  
19. (a) (Date received local registrar)..... (b) (Registrar's signature).....

23. Signature W. B. Brown (M. D. or other).....  
Address.....

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

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

30319